HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

How Two Hospitals Met Crisis

A train wreck—page 31
Unrest in Lebanon—page 37

Health Insurance Newsletter

A new feature
page 51

TV Monitor In Pediatric Unit

page 87

BUYER'S GUIDE
Page 66

ter Miriam Thomas, S.C.S.E. (see page 5)

The News Magazine for Hospitals

NOVEMBER | 1958

NEW

VI-CERT C1000

SOLUBLE B VITAMINS with C and B_{12}

in a single dose **INCERT® *vial for I.V. solutions***

This newest addition to the INCERT® family of "closed system" additives makes available essential components of the B complex, plus vitamin C and B_{12} for routine parenteral administration.

No needles, ampules or syringes to fuss with. Simply reconstitute the lyophilized mixture in the INCERT vial by pumping fluid from the solution bottle . . . pump the mixture back into solution bottle . . . and it's ready for administration.

Clinical reports[1,2,3] suggest that large doses of vitamin C are beneficial in decreasing the incidence of post-traumatic and postoperative shock, in improving wound healing and in hastening the healing of extensive burns.

Vitamin B_{12} has been suggested as an adjunct to therapy in the elderly patient undergoing operation or any other severe stress[4] and for use in the prevention of depressed hemopoiesis and disturbed enzyme activity which may occur during severe illness, following burns, after radiation therapy, or in certain pathologic states.

Complete information on the Incert System available upon request.

References

1. Holmes, H. H.: The Use of Vitamin C in Traumatic Shock, Ohio State M.J. 42: 1261-1264, December 1946.

2. Levenson, S. M., Green, R. W., Taylor, F. H. L., Robinson, P., Page, R. C., Johnson, R. E., and Lund, C. C.: Ascorbic Acid, Riboflavin, Thiamin and Nicotinic Acid in Relation to Severe Injury, Hemorrhage and Infection in the Human, Ann. Surg. 124: 840-856, November 1946.

3. Andrus, W. D., and Barnes, W. A.: Pre and Post-Operative Care of the "Poor Risk" Patient, Surg. Clin. N. Am. 25:350-360, April 1945.

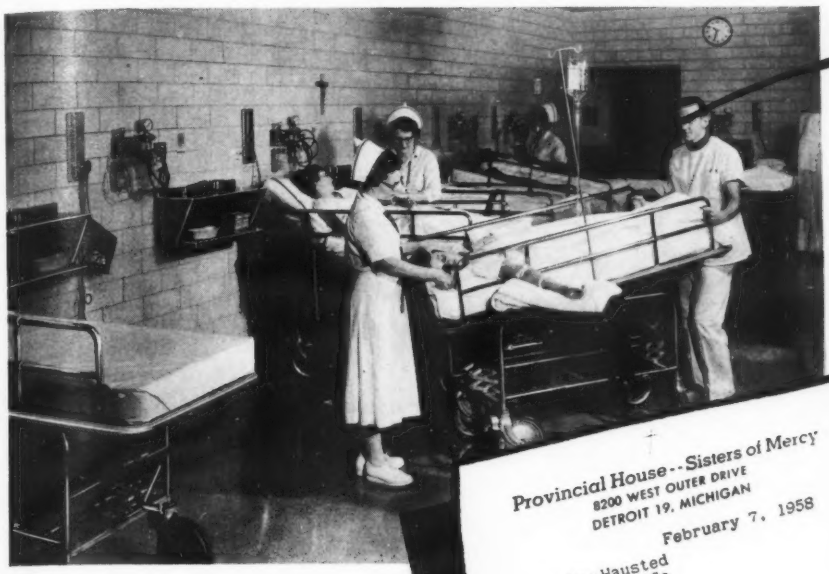
4. Ross, G. I. M., Mollin, D. L., Cox, E. V. and Ungley, C. C.: Hematologic responses and concentration of vitamin B_{12} in serum and urine following oral administration of vitamin B_{12} without intrinsic factor, Blood 9:473-488, May 1954.

TRAVENOL LABORATORIES, INC. *pharmaceutical products division of*

morton grove, illinois **BAXTER LABORATORIES, INC.**

Another new RECOVERY ROOM is equipped with

Hausted WHEEL STRETCHERS...



Provincial House -- Sisters of Mercy
8200 WEST OUTER DRIVE
DETROIT 19, MICHIGAN

February 7, 1958

Mr Ray Hausted
Hausted Mfg Co
Medina, Ohio

Dear Mr Hausted

Over a period of years we have used the Hausted Stretcher in the hospitals operated by the Sisters of Mercy, Province of Detroit It was therefore logical, when the Recovery Room was opened in Mt Carmel Mercy Hospital, that we should use the stretcher that has given service, protection and patient comfort

Mother Mary Nicholas R S M

Mother Mary Nicholas, R S M
Mother Provincial

MOUNT CARMEL MERCY HOSPITAL IN DETROIT PREFERS HAUSTED EQUIPMENT ABOVE ALL OTHERS. Why? Because over the years Hausted wheel stretchers prove themselves to be the most modern, efficient and versatile unit available. Hausted stretchers eliminate many patient transfers and make it today's best unit for EMERGENCY and RECOVERY ROOM use. The patient without being transferred can be taken from receiving or surgery through complete emergency or recovery service and then be removed to his bed. Only Hausted's unique design and quality construction give the necessary ruggedness and mobility necessary for such an efficient application. When you are considering new equipment for YOUR *Emergency or Recovery Room* consider Hausted equipment, it's the finest.

HAUSTED BUILDS A STRETCHER FOR EVERY NEED AND BUDGET

Hausted MANUFACTURING COMPANY

MEDINA, OHIO

HOSPITAL Topics
GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES
NOVEMBER, 1958, VOL. 36, NO. 11

FEATURES

Administrator's Digest: 19
American College of Surgeons 19
Indiana Hospital Association 25

The Patient-Nurse Communication System of Tomorrow—Here Today 28
James G. Harding

Hospital Rides a Hobby Horse 30

Preparedness Pays When Disaster Strikes 31
Sister Miriam Thomas, S.C.S.E.

Medical Care Under the Guns 37
A Report from Lebanon
Richard E. Sawyer

Alcoholism: Its Nature and Treatment 40
Part II. Professional Treatment
The Rev. John J. Lazarsky, O.M.I.

Nursing Services in the Hospital 45
I. Organization of the Nursing Service
John H. Gorby

Tasting Table Helps Dietitians Add Variety to Staff Menus 50
Helen M. Sims and Elizabeth McCune

Health Insurance *Newsletter* 51
Sen. George R. Metcalf

Regional Differences in U.S. Hospitals 55
Eleventh in a Series—Payroll Expenses
Louis Block, Dr. P.H.

Hobby Show — Page 30

DEPARTMENTS

Scanning the News 7
News Briefs 9
Calendar of Meetings 10

(Continued on page 5)

Disaster — page 31

G. M. MARSHALL
Publisher

MARIE JETT
Editor

J. F. FLEMING, M.D.
Medical Editor

JOHN G. STEINLE
Consulting Editor

FRANCES LARSON
Managing Editor

ELLEN L. DAVIS
Feature Editor

ANNA MAE MULL
Editorial Assistant

GUNHILD MOBERG
Business Manager

SARAH McCOLLUM
Production Assistant

MARCELLA SKANDIS
Assistant to the Publisher

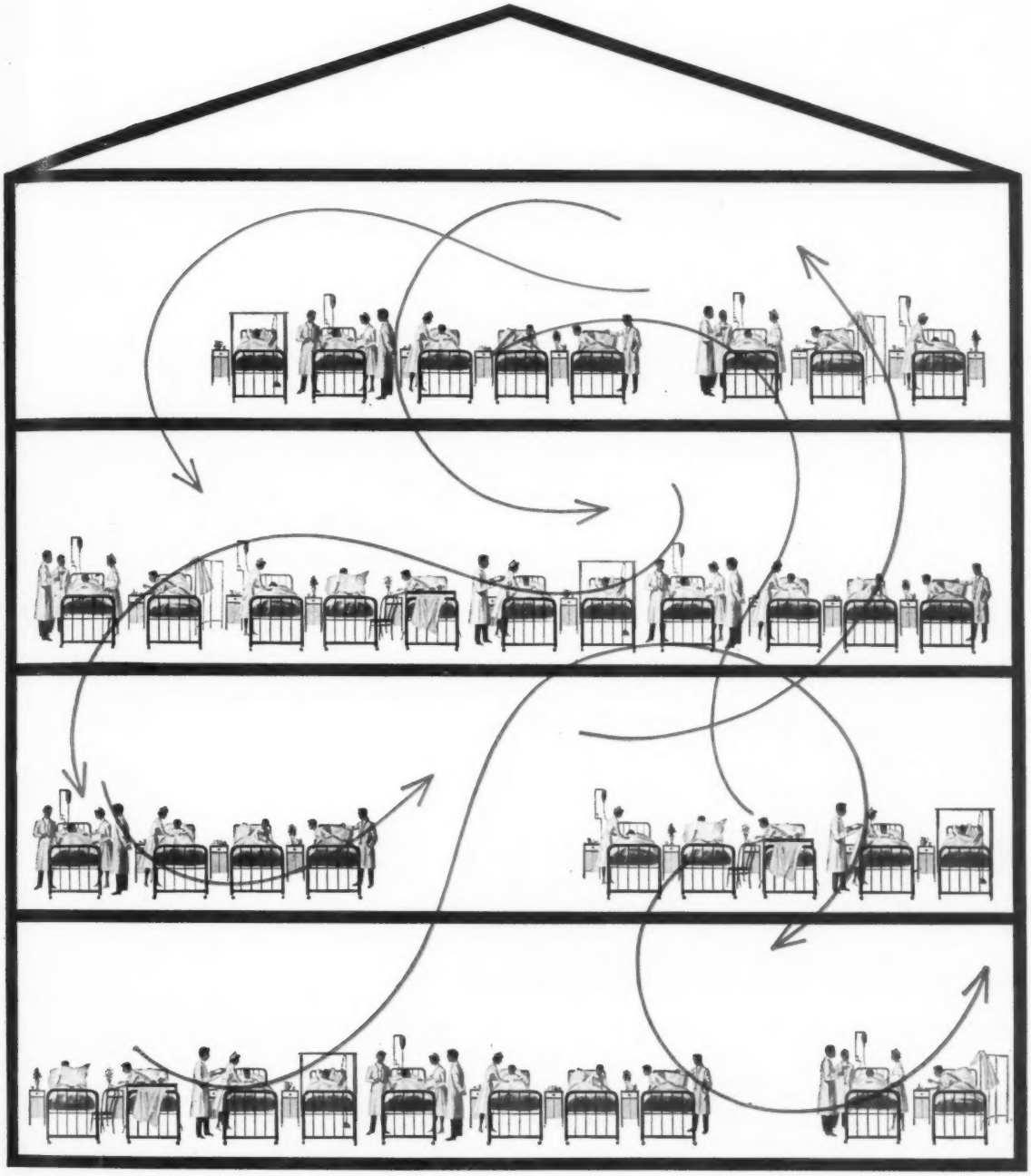
VIRGINIA PAGE, JOHN HOGENSEN
Advertising Representatives

Published monthly by HOSPITAL TOPICS, INC. Publication office: 30 West Washington St., Chicago 2, Ill. Telephone DEarborn 2-5148.

Eastern Sales Office: 15 W. 44th St., New York 36, N. Y. Telephone OXford 7-5262.

Subscription rates: one year, $4.50; two years, $7.00; three years, $9.00; single copy, 65 cents. Canadian and foreign subscriptions: one year, $5.50; two years, $9.00; three years, $12.00; single copy, 75 cents. Entered as second class matter at the Post Office, Chicago, Ill.

Change of address notices, undeliverable copies, and subscription orders should be sent to: HOSPITAL TOPICS, 30 West Washington St., Chicago 2, Ill.



STOP "HOSPITAL STAPH" WITH ALBAMYCIN*

Antibiotic-resistant strains of Staphylococcus are meeting their match in Albamycin. Because Albamycin shows no cross resistance with any commonly used antibiotic, it is dramatically effective against unyielding staphylococcal pneumonia or superinfections of pneumococcal pneumonia.

Whether resistant staph is known or suspected, *Albamycin is indicated.*

ADMINISTRATION AND DOSAGE: The dosage for adults is 500 mg. Albamycin administered intramuscularly or intravenously every 12 hours. As soon as the patient's condition permits, parenteral Albamycin should be replaced with oral Albamycin therapy.

SUPPLIED: Available as 250 mg. capsules; syrup containing 125 mg. Albamycin per 5 cc.; and in the 500 mg. Mix-O-Vial.†

*TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM
†TRADEMARK, REG. U. S. PAT. OFF.

The Upjohn Company, Kalamazoo, Michigan

Upjohn

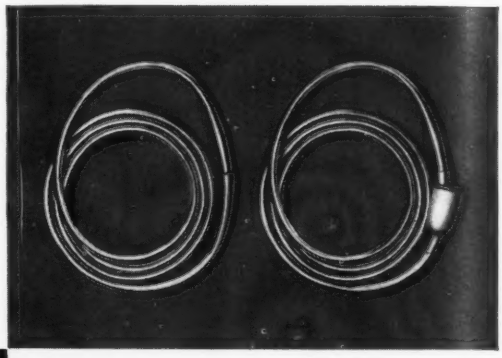
When You Order
Plastic Catheters or
Surgical Tubes **remember...**

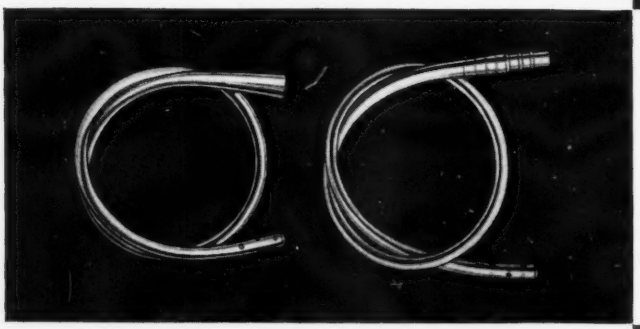
DAVOL OFFERS A STYLE AND SIZE FOR EVERY HOSPITAL NEED

4 DRAIN TUBES—FOR OPEN OR CLOSED SYSTEMS

For Open System—Davol Urine Drain Tube. 3/16 or 9/32 I.D. Tubing ends are sealed—to place in use simply twist tube ends apart. Catheter connector is an integral part of tube itself—is easy to assemble and gives tight, secure fit.

For Closed System—Davol Urine Drain Tube with Adapter Cap. 3/16 or 9/32 I.D. Tube with latex adapter to fit over neck of drainage bottle for closed system. Caps have vent holes to prevent vacuum and insure constant fluid flow.





OXYGEN AND SUCTION TUBES with Funnel or Connector Ends

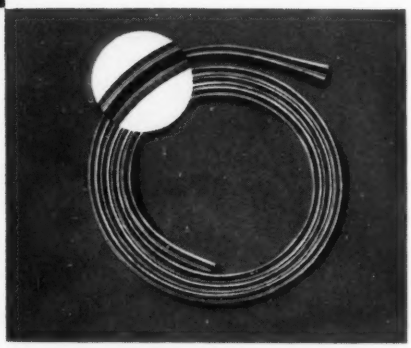
Assembled either with Nylon Connectors or the new Davol design with full-flared funnel, that eliminates need for extra Connectors.

LEVIN TUBES—TRANSPARENT OR X-RAY OPAQUE

Davol Levin Tubes are available in three styles—

1. Transparent with X-ray Opaque Line (as illustrated).
2. Transparent.
3. White X-ray Opaque, not Transparent.

All Levin Tubes with markings 18", 22", 26", 30" from distal end—smoothly bevelled eyes to minimize trauma. Inside surfaces are satin smooth.



For further information on the most complete *line of plastic catheters and surgical tubes, contact your hospital supply dealer or write Davol Rubber Company, Providence, Rhode Island.*

DAVOL *For Over 80 Years Your Assurance of Quality*

TABLE OF CONTENTS

(Continued from page 2)

Consultant's Corner 56
John G. Steinle

Review of Hospital Law Suits..... 58
Leo T. Parker

Personally Speaking 62

Buyer's Guide 66

Films, New Literature..... 77

TOPICS Takes Camera Tour of ACS Exhibits.... 78

The Pharmacy 81
Stopping Phone Jangle in the Pharmacy
E. Byron Smith
Prescription Pad
Clinical Notes

The Lab 85

Pediatrics 87
Closed-Circuit TV System
Monitors Pediatrics Patients

O.B. Department 91
The Mothercraft Concept in Maternity Care
Kate H. Miles

Central Supply 129
New Surgical Dressing Technic Helps
Hahnemann Combat Staph
Cecilia D. Yastremski, R.N.

Trade Topics 137

The Book Corner 140

OPERATING ROOM

Sixth AORN Program is Texas-Big.....101

A Sterile, Waterproof, Plastic Operative Field....102
Carl W. Walter, M.D., and Richard E. Wilson, M.D.

O.R. Procedure Manual for Open-Heart Surgery..105
Part II. Equipment and Supplies for Pump Team
Audrey N. Bell, R.N.

O.R. Question Box 108
Carl W. Walter, M.D.

O.R. Problem Clinic.....110
Edith D. Hall, R.N.

Selected Bibliography 113
Dorothy W. Errera, R.N.

Houston or Bust?
Try Your Skill in These Contests.....114

Program for 6th AORN Congress.....115

Introducing AORN Technical Exhibitors.....120

HOSPITAL *Topics*

PERSONALITY OF THE MONTH

TO Sister Miriam Thomas, administrator, Good Samaritan Hospital, Suffern, N.Y., preparedness is more than a motto. It is a basic philosophy and one which has proved to have practical, even lifesaving, results.

On page 31, Sister Miriam tells how previous preparations for an emergency enabled Good Samaritan to handle the victims of a nearby train disaster last year.

Joining the Good Samaritan staff in 1948, Sister Miriam began looking toward the future needs of the institution. Within the past eight years, two major building programs have been undertaken.

Born in Pawtucket, R.I., Sister Miriam graduated from the St. Elizabeth Hospital School of Nursing, Elizabeth, N.J., in 1928. She has also taken extension courses at the College of St. Elizabeth, Convent Station, N.J., and Seton Hall University, South Orange, N.J. She entered the order of the Sisters of Charity of St. Elizabeth in 1931 at Convent, N.J.

Sister Miriam served as assistant administrator at St. Vincent's Hospital, Montclair, N.J., from 1935 to 1939, and as assistant administrator at St. Joseph's Hospital, Paterson, N.J., from 1939 to 1941. At St. Joseph's she was superintendent of nurses from 1941 to 1948.

She was one of the first in her order to receive fellowship in the American College of Hospital Administrators. She became a member of the college in 1940, a fellow in 1951.

In addition to her work at the hospital, Sister Miriam is also a member of the board of directors of the Rockland County (N.Y.) unit of the American Cancer Society.

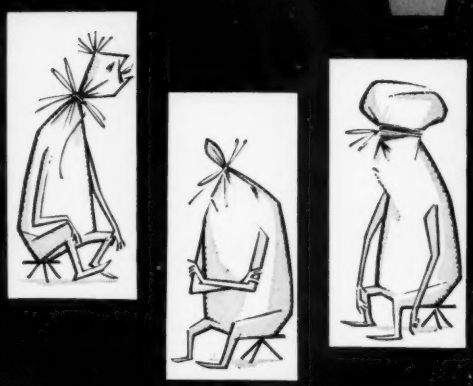
Last year, she received a special "Good Turn" certificate from the Boy Scouts of America for offering her hospital's facilities, in the advent of an emergency, to the Boy Scouts during a regional Camporee.

In 1956, Sister Miriam was named "Woman of the Year" by the Rockland County (N.Y.) Business and Professional Women's Club.

in respiratory infections

NEW **V-KOR**™

(penicillin V potassium compound, Lilly)



Therapeutic trio brings rapid relief

V-Kor combines in a single tablet:

V-Cillin K®—*destroys bacterial invaders*
Provides higher blood levels than any other oral penicillin; there are no "nonabsorbers."

Co-Pyronil™—*relieves congestion*
Provides quick and prolonged antihistaminic action plus vasoconstriction.

A.S.A.® Compound—*controls fever and pain*
Provides analgesia and antipyresis.

V-Kor is valuable in acute respiratory infections. It quickly eliminates susceptible organisms and controls annoying symptoms. Rapid recovery and patient comfort are thus well assured.

Usual adult dosage is 2 tablets every six or eight hours. Supplied as attractive green-white-yellow tablets.

V-Cillin K® (penicillin V potassium, Lilly)
Co-Pyronil™ (pyrrobutamine compound, Lilly)
A.S.A.® Compound (acetylsalicylic acid and acetophenetidin compound, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

831012

For additional information on products advertised, circle number on reply card opposite page 152.

HOSPITAL Topics
The News Magazine for the Hospital Staff

NOVEMBER, 1958
VOL. 36, NO. 11

Scanning the News

Water Balloon Used In "Deep Freeze" Surgery

A new method of preparing a patient for "deep freeze" surgery involves inserting a balloon into the stomach of the patient, then filling the balloon with cold water. The technic was described recently by F. John Lewis, M.D., Northwestern University, Chicago.

Cooled blood reaches the vital organs much faster from within the stomach, according to Dr. Lewis, because of the area's rich supply of blood vessels.

After the balloon is inserted, it is filled with about a pint of water. Temperature is controlled by running the water through coils.

Discover Older People Visit Clinics for Companionship

Investigation by the Comprehensive Medical Psychiatry Service at Mount Sinai Hospital, Chicago, has revealed that older people attend hospital clinics searching for security and companionship in the guise of medical attention.

The service was started two years ago because of the number of older people who were returning for treatment of ailments not serious enough to warrant the amount of clinical hours and services being expended upon them. A patient-by-patient study resulted in chronic clinic visitors being withdrawn and assigned to the new department.

Ultrasonic Technic Aids Eye Disease Diagnosis

A new technic using ultrasound for more accurate diagnosis of certain eye disease was demonstrated at the American Medical Association meeting in San Francisco, by Gilbert Baum, M.D., attending ophthalmologist, VA Hospital, Bronx, N.Y.

Though active in business, Lucille Shaw has been paralyzed in both legs and confined to a wheelchair since a polio attack in 1926. Several months after her marriage in 1955, her husband Bert developed and patented a 3-sectional aluminum ramp for his wife called "Travel-Tric," equipped with legs and rockers which make it possible to move her in and out of a car. Shifting automatically into the most convenient position for moving the occupant, the ramp's design prevents free-wheeling rollbacks. In full-length position, with legs and rockers closed, it serves as a ramp for mounting low steps. "Travel-Tric" weighs 20 pounds, folds into a 24" x 26" x 6" unit. Shaw is currently surveying the demand for such a ramp and may produce them in volume.

The ultrasonic technic provides a cross-sectional view of the eye even when the tissues are totally opaque. The "seeing" is accomplished by high frequency sound waves which penetrate the opaque areas like radar and record on a viewer the areas not visible to light or x-rays.

The instrument, developed by Dr. Baum and Ivan Greenwood, associate chief of research, Avionics Division, General Precision Laboratories, can be used in eye surgery to locate precisely tumors or foreign bodies which have penetrated the eye. It can also be used for diagnosis and is safe, they said.

Soot and Dust Disease Endangers Space Fliers

A VA study showing that chronic pulmonary emphysema tends to develop in areas of soot and dust deposit in the lungs will probably affect space fliers.

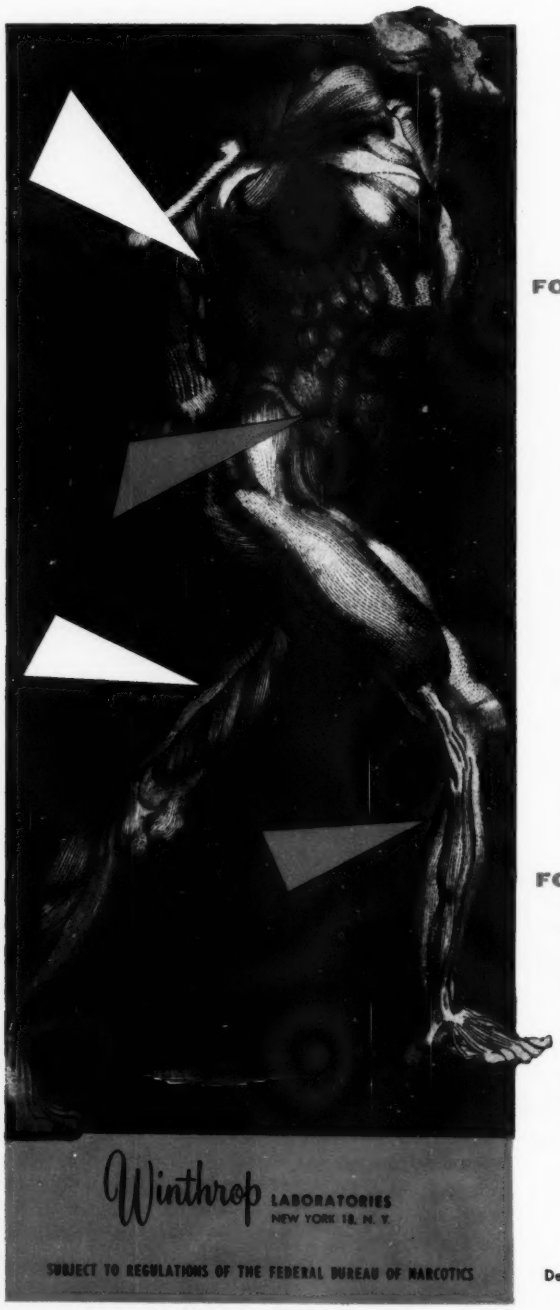
Charles P. Oderr, M.D., director of the study, said it would be dangerous for persons with emphysema to be selected as space or high altitude pilots. Air would become trapped in the infected portions of their lungs if the pressure inside the cabin dropped suddenly, he pointed out.

for dependable, uniform, predictable response...

Demerol®

a dosage form

for every type of pain



FOR PARENTERAL USE

5% solution (50 mg. per cc.)
Ampuls of 0.5 cc. (pediatric)
Ampuls of 1 cc.
Ampuls of 1.5 cc.
Ampuls of 2 cc.
Vials of 30 cc.

10% solution (100 mg. per cc.)
Ampuls of 1 cc.
Vials of 20 cc.
Disposable syringes of 1 cc.

Demerol with Scopolamine (50 mg. Demerol HCl and 1/300 grain scopolamine HBr per cc.)
Ampuls of 2 cc.
Vials of 30 cc.

Demerol with Atropine (50 mg. Demerol HCl and 1/300 grain atropine sulfate per cc.)
Ampuls of 2 cc.

FOR ORAL USE

Tablets of 50 mg.

Tablets of 100 mg.

Elixir, nonalcoholic (50 mg. per 5 cc. teaspoon)
pleasant banana flavor — especially useful for children

Powder, vials of 15 Gm.

A.P.C. with Demerol tablets, scored tablets containing 200 mg. (3 grains) aspirin, 150 mg. (2½ grains) phenacetin, 30 mg. (½ grain) caffeine, 30 mg. (½ grain) Demerol HCl.

Demerol (brand of meperidine), trademark reg. U. S. Pat. Off.

Demerol "in optimal dose . . . is as potent as morphine."

Beecher, H. K. (Harvard University Medical School): *Brit. J. Anesth.* 29:261, June, 1957

News Briefs at Press Time

BLUM REPORT AFTERMATH; HOSPITALS HOPE FOR SOME GOOD RESULTS

California hospital administrators, still smarting from the sensational and unfair newspaper publicity on the Blum report—a study on malpractice sponsored by the California Medical Association—are hoping some good may still come out of the report.

Orville Booth, new president-elect of the California Hospital Association, told CHA members at annual meeting in late October, "Here is an opportunity for hospitals and medical leaders to sit down and get together, not only to counteract the bad effects of the Blum report, but also to study other problems."

Soon after San Francisco papers carried such banner headlines as "Secret Medical Report Blasts Hospitals in California," a special session of the subcommittee of the State Assembly's Committee on Public Health met and heard medical testimony refuting some of the material in report.

George Crawford, chairman of subcommittee on hospitals, then was asked to conduct a further investigation to determine whether charges in report are true, and if so, what legislation is needed to correct the conditions. California hospital leaders think Crawford is competent and will conduct a fair investigation.

Somehow when copies of the report by psychologist Richard H. Blum were distributed to key persons in the CMA, one copy got into the hands of a San Francisco news reporter. Without attempting to verify any of the information, he broke the story. Reasons administrators and physicians feel they received unfair treatment from the press:

—Material played up in articles was taken from two pages of 341-page report. These two pages were miscellaneous comments from people in one "high-suit" hospital and were discounted by researcher Blum.

—Entire report was based on study of only five hospitals—all in Alameda and Contra Costa counties. Three were hospitals whose staff members had a high incidence of malpractice suits. The other two were "low-suit" hospitals.

—Most of material in 2½-year study was prepared in 1955. Some information dated back as much as seven years. No recognition was paid to CHA's outstanding safety program which has resulted in reduction of accidents in hospitals and corresponding reduction of professional liability insurance rate for hospitals.

PHYSIOLOGIST USES SELF AS GUINEA PIG IN BEHALF OF DISPUTED CANCER DRUG

Andrew C. Ivy, M.D., University of Illinois physiologist, recently gave himself a dose of the disputed cancer drug, Krebiozen, as a cancer preventive before undergoing surgery for a precancerous lip lesion he attributes to 25 years of heavy pipe smoking.

At the same time, John Heller, M.D., director, National Cancer Institute, indicated he is willing to make a "double-blind" test to study drug.

PHYSIOLOGY AND PHARMACOLOGY EXPERTS TO VISIT RUSSIA ON EXCHANGE BASIS

A new exchange of teams has been arranged with the Soviet. Participants will be experts in physiology and pharmacology of the central nervous system, endocrinology, and biochemistry. The American teams will go to Russia in November, January, and late spring, respectively.

BRIEF BRIEFS

Maj. Gen. Oliver K. Niess will be sworn in as surgeon general of the U.S. Air Force December 1, succeeding Maj. Gen. Dan C. Ogle. Maj. Gen. Niess has been command surgeon of the Pacific Air Forces in Hawaii since 1954 . . . Medical services of the Canadian armed forces will be unified into single service, January 1, 1959, according to recent announcement. Single service will be headed by an army general; unification will apply to all medical officers, nursing sisters, and administrative personnel.

Gordon M. Marshall

Calendar of Meetings

NOVEMBER

1- 5 College of American Pathologists, Congress Hotel, Chicago

2- 8 American Society of Clinical Pathologists, Congress Hotel, Chicago

3- 5 Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D. C.

3- 7 AHA Institute, Medical Record Library Personnel, LaSalle Hotel, Chicago

3- 7 AHA Institute, Nursing Service Administration, Bellevue-Stratford Hotel, Philadelphia

6- 7 Oklahoma Hospital Association, Skirvin Hotel, Oklahoma City

7 Minnesota Hospital Association, Lowry Hotel, St. Paul

10-13 Interstate Postgraduate Medical Association, Public Auditorium, Cleveland, O.

10-14 AHA Institute, Physical Therapy, Bellerive Hotel, Kansas City, Mo.

10-14 American Association of Inhalation Therapists, Kingsway-Ambassador Hotel, St. Louis

12-14 AHA Institute, Hospital Organization, Stephen F. Austin Hotel, Austin, Tex.

12-14 AWH Institute on Hospital Administration and for Hospital Auxiliaries, Princess Kaiulani Hotel, Honolulu, T. H.

13-14 Arizona Hospital Association, Westward-Ho Hotel, Phoenix

13-14 Kansas Hospital Association, Baker Hotel, Hutchinson

14-16 Virginia Hospital Association, Hotel Roanoke, Roanoke

16-18 National Association for Practical Nurse Education, Regional Workshop, New Hampshire Highway Hotel, Concord, N.H.

16-20 National Society for Crippled Children and Adults, Statler-Hilton Hotel, Dallas, Tex.

16-21 Radiological Society of North America, Chicago

17-18 International College of Surgeons, Mid-Atlantic Meeting, Homestead Spa, Hot Springs, Va.

17-19 AHA Institute, Hospital Organization, Somerset Hotel, Boston

17-19 Association of Military Surgeons of the U.S., Hotel Statler, Washington, D.C.

18-20 First National Conference on Air Pollution, U. S. Department of Health, Education and Welfare, Sheraton Park Hotel, Washington, D. C.

18-20 AHA Institute, Disaster Planning, Ambassador Hotel, Los Angeles

19-21 Missouri Hospital Association, President Hotel, Kansas City, Mo.

20-21 Florida Hospital Association, George Washington and Pennsylvania Hotels, West Palm Beach, Fla.

20-22 American Association of Blood Banks, Netherland Hilton Hotel, Cincinnati, Ohio.

20-22 Western Surgical Association, Kahler Hotel, Rochester, Minn.

21-23 National Association for Practical Nurse Education, Regional Workshop, Willard Hotel, Washington, D.C.

26-30 Catholic Hospital Association, Committee on Medical Technologists, Biochemistry Workshop, St. Mary's College, Xavier, Kans.

(Continued on page 12)

Before buying sutures consider these facts . . .

1. BASIC PRICES OF GUDEBROD non-absorbable sutures have not changed since 1946.

2. Real economy can be achieved by sterilizing sutures purchased in bulk (in spools) instead of expensive fancy packages.

3. Your silk-using surgeons know the superior handling qualities and greater strength after sterilization of Gudebrod Cerethermic Finish.

4. Your O.R. team appreciates the convenience of Gudebrod COLOR-CODED sutures.

5. Champion Serum-Proof Silk and Hand-Craft cotton are available in many "convenience" packages as well as spools.

Check your delivered prices. And — for economy, convenience and satisfaction, you'll buy Gudebrod.

Gudebrod

GUDEBROD BROS. SILK CO., INC.

Surgical Division: 225 West 34th Street, New York 1, New York

Executive Offices: 12 South 12th Street, Philadelphia 7, Penna.

CHICAGO • BOSTON • LOS ANGELES

CALENDAR OF MEETINGS

(Continued from page 10)

DECEMBER

1- 5 American College of Hospital Administrators, First Southwestern Advanced Institute, Dallas, Tex.

1- 5 AHA Institute, Methods Improvement, Cosmopolitan Hotel, Denver

2- 5 American Medical Association, Clinical Meeting, Municipal Auditorium, Minneapolis

4- 5 Illinois Hospital Association, Abraham Lincoln Hotel, Springfield

6-11 American Academy of Dermatology and Syphilology, Palmer House, Chicago

8-11 AHA Institute, "Staffing" Departments of Nursing, Shoreland Hotel, Chicago

8-12 AHA Institute, Hospital Housekeeping, Ambassador Hotel, Los Angeles

9-11 Southern Surgical Association, Boca Raton Club and Hotel, Boca Raton, Fla.

11-13 AHA Institute, Methods Improvement, Cosmopolitan Hotel, Denver

26-31 American Association for Advancement of Science, Washington, D.C.

1959 MEETINGS

JANUARY

4- 7 International College of Surgeons, Southeastern Regional Meeting, Miami, Fla.

21 Comite des Hopitaux du Quebec, Montreal, Que., Canada

23-24 Alabama Hospital Association, Admiral Semmes Hotel, Mobile

24-29 American Academy of Orthopaedic Surgeons, Palmer House, Chicago

27-29 National Association of Methodist Hospitals and Homes, Jefferson Hotel, St. Louis

27-30 American Protestant Hospital Association, Jefferson Hotel, St. Louis

FEBRUARY

4- 5 AHA Midyear Conference of Presidents and Secretaries, Palmer House, Chicago

4- 7 American College of Radiology, Chicago

9-11 Association of Operating Room Nurses, Shamrock-Hilton Hotel, Houston, Tex.

19-21 Central Surgical Association, Montreal, Que., Canada

MARCH

5- 6 Georgia Hospital Association, Bon Air Hotel, Augusta

5- 7 Louisiana Hospital Association, Bellemont Motor Hotel, Baton Rouge

10-12 American Laryngological, Rhinological, and Otological Society, The Homestead, Hot Springs, Va.

17-19 National Health Council, Palmer House, Chicago

23-25 New England Hospital Assembly, Hotel Statler, Boston

30-April 1 Southwestern Surgical Congress, New Brown Palace Hotel, Denver

31-April 2 Kentucky Hospital Association, Phoenix Hotel, Lexington

APRIL

1- 3 Mid-West Hospital Association, Municipal Auditorium, Kansas City, Mo.

5- 9 American College of Obstetricians and Gynecologists, Traymore Hotel, Atlantic City, N.J.

6- 8 American Radium Society, The Homestead, Hot Springs, Va.

6- 9 American Academy of General Practice, San Francisco

6- 9 Ohio Hospital Association, Veterans Administration Auditorium, Columbus

8-10 Southeastern Hospital Conference, Atlanta-Biltmore Hotel, Atlanta, Ga.

15-17 American Surgical Association, Fairmont Hotel, San Francisco

16-17 Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va.

20-23 Congress of International Anesthesia Research Society, Miami Beach, Fla.

20-24 American College of Physicians, Conrad Hilton Hotel, Chicago

23-25 American Association of Pathologists and Bacteriologists, Somerset Hotel, Boston

27-29 Aero Medical Association, Hotel Statler, Los Angeles

(Continued on page 15)

A SHAMPAINE INDUSTRY
Shampaine ELECTRIC CO.
one of nine separate companies now organized under one great name...
SHAMPAINE industries
...offering the most complete equipment line in the institutional and professional fields.
Shampaine Company
Shampaine Electric Co., Inc.
O. E. M. Corporation
Professional Specialties, Inc.
W. D. Allison Company
Carrom Industries, Inc.
Crown Products
Harley Corporation
Richard Phillip Company
AN OUTSTANDING PRODUCT OF SHAMPAINE INDUSTRIES
THE SUPER-MEALCART

THE LATEST ADVANCE IN PORTABLE FOOD SERVICE EQUIPMENT
KEEP YOUR EYE ON SI SHAMPAINE Industries

Serve your meals WITH Shampaine ELECTRIC

Super-Mealcart. (Design Pat. Pending) (S-3010-MR Illustrated 20 Trays with Beverage Bar S-3010)

SUPER-MEALCART

Represents the latest advance in efficient portable food service equipment for centralized tray systems. The famous step-down feature (design pat. pend.) provides work surface for set-up and beverage dispensing from exclusive removable beverage bar (S-3010). Large drawers with generous clearance allow room for half-pint milk containers and full complement of dinnerware. Drawer depth in hot side permits clearance for coffee cups. Coffee is dispensed from beverage bar into pre-heated cups. Available in *mechanical refrigeration* and *cartridge type refrigeration* models.

MECHANICAL REFRIGERATION MODELS

Mechanical refrigeration with hold-over cooling capacity for a full hour *without* running compressor or blower. Will hold and retain 38° F. even in room temperature of 90° F.

S-3001-MR	(20 trays)
S-3002-MR	(24 trays)
S-3003-MR	(30 trays)

CARTRIDGE TYPE REFRIGERATION MODELS

(CARTRIDGES NOT INCLUDED)

S-3001-DP	(20 trays)
S-3002-DP	(24 trays)
S-3003-DP	(30 trays)

ONLY SHAMPAINE ELECTRIC SUPER-MEALCART HAS . . .

- an unobstructed set-up area *convenient* counter height, at 41" for 20-meal cart, at 44" for 24-meal cart. Accommodates large trays up to 15½" x 20½".
- all stainless steel, double-walled, fully-insulated construction throughout. 2½" insulation between hot and cold compartment.
- compact heated drawers accommodating three 9" dinner plates, *plus* three 5½" plates, *plus* three coffee or tea cups
- an oven compartment with internal, waterproof installed, stainless steel, sheathed sealed heaters. Accessible *without* dismantling or turning cart upside down. Provides uniform temperatures (185° F.) throughout compartment.
- fully-insulated, recessed and double-walled doors of oven compartment close tightly against recessed frame. Full-length *stainless steel* piano hinges on doors.
- rugged, compact tray slides that can be removed in easy to clean *sections*, providing clearance between tray slides of 3¾" for ½ pint "carton-type" milk container.
- models in 20, 24 and *30-meal size, for both *mechanical* and *eutectic* refrigeration (Dole cartridge), and with or without beverage dispensers.

*at additional set-up charge.

S-3010 Beverage Dispenser
(Cart Not Included)

REMOVABLE BEVERAGE BAR S-3010

Removable, easy to load, easy to clean beverage bar with *separate*, individually insulated wells permitting dispensing of boiling water from one and cooled drinks from the other. Bar can be used in combination with utility truck for "between-meal" coffee or fruit juice servings to patients or can be set up in Doctors Lounge.

Electric, three well—each well individually thermostatically controlled stainless steel.

SHAMPAINE ELECTRIC COMPANY, INC. *THE COMPLETE FOOD CONVEYOR LINE*

50 Webster Ave. • New Rochelle, N. Y.

a SHAMPAINE industry

SPEEDIEST SAFEST DELIVERY SERVICE

...VIA SHAMPAINE O. B. TABLE

THE HAMPTON

Created by Shampaine research to assure "the world's safest delivery!"

WITH TRUE HEAD-END CONTROL

This distinguished piece of the Shampaine line brings to your delivery room many advanced features for greater speed, ease, safety and patient comfort:

- True head-end control of all positions
- Shift from labor to delivery with a single, swift control
- Telescoping leg section controlled from head end—body section remains stationary at all times
- Universally adjustable crutch sockets
- Simple, functional, compact design
- Stainless steel side panels on body, leg section and front
- Available as S-2602 with painted base S-2602 with S-2602-SS stainless steel base

WRITE FOR DETAILS

Shampaine

1920 S. JEFFERSON ST. LOUIS, MO.

a SHAMPAINE Industry

CALENDAR OF MEETINGS

(Continued from page 12)

APRIL

27-29 Tri-State Hospital Assembly, Palmer House, Chicago

27-May 1 American Psychiatric Association, Civic Auditorium, Philadelphia

27-May 1 National Association for Practical Nurse Education, Netherland Hilton Hotel, Cincinnati, O.

MAY

4- 7 Association of Western Hospitals, Hotel Utah, Salt Lake City

11-13 Canadian Hospital Association, Queen Elizabeth Hotel, Montreal, Que., Canada

11-15 National League for Nursing, Philadelphia

12-14 Texas Hospital Association, Shamrock-Hilton Hotel, Houston

13-15 Upper Midwest Hospital Conference, St. Paul Auditorium, St. Paul, Minn.

20 New Jersey Hospital Association, Convention Hall, Atlantic City, N.J.

20-22 Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N.J.

JUNE

1- 4 Catholic Hospital Association, Kiel Auditorium, St. Louis

1- 6 International Hospital Congress, Edinburgh, Scotland

JULY

16-24 Canadian Medical Association, Edinburgh, Scotland

19-25 International Congress of Pediatrics, Montreal, Que., Canada

AUGUST

24-27 American Hospital Association, The Coliseum, New York City

30-September 4 Second World Conference on Medical Education, Palmer House, Chicago

SEPTEMBER

6-12 World Congress for Physical Therapy, Paris, France

OCTOBER

26-28 Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D.C.

26-28 National Rehabilitation Association, Boston

Fat Builds More Fat Fast Research Team Discovers

Fat is not stored in the body as inert padding, a VA research team has discovered. Instead, it tends to produce more fat at a prodigious rate.

David D. Feller, Ph.D., and Elmer Feist, research assistant, VA Hospital, Seattle, Wash., incubated various mouse tissues and fed them such compounds as glucose, acetate, propionate, and methylmalonate. Fat was produced by fat tissue more than 100 times as fast as by tissue from the liver, they found.

They also discovered that fat tissue builds fat by a different chemical pathway than that used by other tissues. For example, fat builds fat from acetate, whereas other tissues convert it to nonfat substances.

The findings may be the basis for further research on abnormal use of fats by the body, such as that associated with arteriosclerosis.

NEW topical germicide unsurpassed for broad range activity

BETADINE®

Brand of Povidone-Iodine

kills outright

including resistant staph.

KO

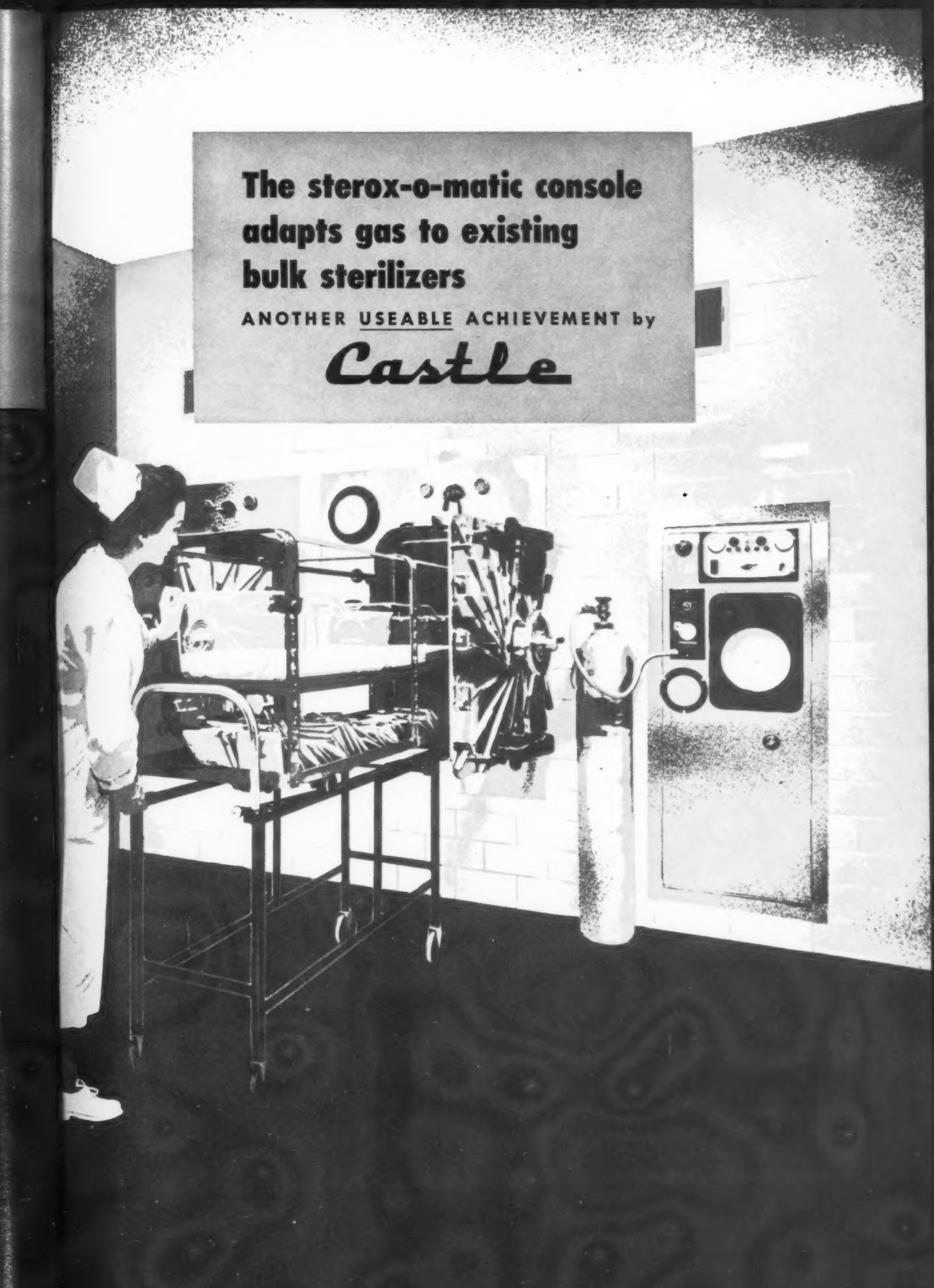
- Kills by contact a wide variety of microorganisms such as *Bacteria (including tubercle bacillus), Viruses, Fungi, Protozoa.* • Effective against certain important organisms resistant to topical antibiotics • Will not lead to the development of resistant strains • Effective even in the presence of blood, pus or other organic matter • Color can be washed off with water.

Available: Betadine Antiseptic in 8 oz., 16 oz., and gallon bottles. Betadine Aerosol in 3 oz. bottles.

Samples and literature upon request.

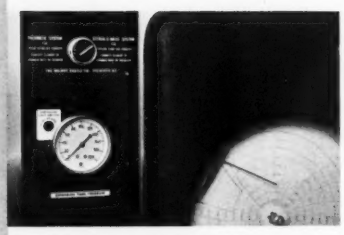
...YET VIRTUALLY NONIRRITATING TO SKIN AND MUCOSA

TAILBY-NASON COMPANY, INC.
DOVER, DELAWARE

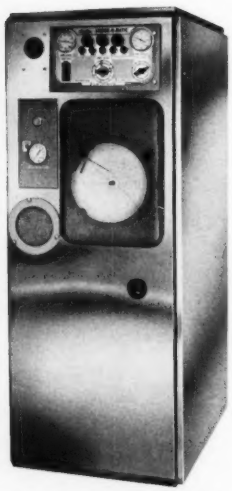

The sterox-o-matic console
adapts gas to existing
bulk sterilizers
ANOTHER USEABLE ACHIEVEMENT by
Castle

ANOTHER *USEABLE* ACHIEVEMENT

Now your hospital can afford bulk gas sterilization



With addition of a special steam-gas interlock The Castle Sterox-O-Matic System may be used for both steam and gas processing. Selector switch mounts on front of console.



The Sterox-O-Matic System virtually runs itself—providing automatic control of time, pressure, vacuum, temperature, humidity and gas concentration through all process phases.

By connecting a Castle Sterox-O-Matic Console to your existing steam chamber, it is now possible to benefit from bulk gas sterilization without the expense of buying a new sterilizer.

That's because the Sterox-O-Matic control system can be made as an independent installation. That's its great advantage. The precise conditions for swift steam or gas sterilizing are automatically maintained in the parent sterilizer chamber by the remote control console unit.

With this system, *your* hospital can sterilize packaged bulk supplies. Anesthesia equipment. Bassinets. Infant incubators. A fully assembled heart-lung oxygenator—and many other loads hitherto difficult or impossible to sterilize.

And for gas sterilizing of smaller heat and moisture-sensitive items such as cystoscopes, catheters, gloves, eye instruments, and cameras, the new Castle Sterox-O-Matic Straightline Sterilizer incorporates both controls and sterilizer chamber in one compact gas sterilizing unit.

IMPORTANT

Help stop Staphylococcus. The use of the Castle Sterox-O-Matic Console makes it possible to bulk sterilize personal contact items previously difficult to sterilize. Blankets, sheets, pillows, rubber sheeting, infant mattresses, etc., may be Steroxcide sterilized countless times without discoloration or injury.

Write today for Catalog 5

WILMOT CASTLE COMPANY
BOX 629 • ROCHESTER 2, N. Y.

1883
1958

Diamond Jubilee Anniversary

Castle

PIONEERS IN SURGICAL EQUIPMENT SINCE 1883

Printed in U.S.A.

American College of Surgeons--

Chicago, October 6-10

Mother's Grafts

Skin Grafts from Mother to Child More Effective Than Those from Father

Skin grafts from mother to child were more successful than those from father to child, we found in two series of experiments. Grafts exchanged between mothers and children lasted 30 days or more in 25 percent of cases.

The parent for the graft was chosen on the basis of compatible blood grouping with the infant, as to AB, O, and Rh factor. In the first series of 19 pairs, each infant received an injection of 4 cc. of whole blood from the parent who was to donate the graft. Blood injections were given when the infants were three to 28 days of age, and grafts were exchanged when the infants were two to three months of age.

There was early rejection of all skin grafts exchanged between fathers and boy or girl infants.

In the second series of 33 pairs of parents and infants or children, the same pattern of survivals was evident.

The longer survival of homografts from mother to child suggests that tolerance between mother and child may occur because of fetal exposure to maternal antigens.

Our preliminary findings suggest the advisability of using mothers as donors of skin grafts for severely burned children. Also, the prolonged survival time of some grafts from mother to child suggests the possible clinical value of blood transfusions from mother to child rather than from fathers or unrelated donors.

Moreover, a child who tolerates his mother's skin may also tolerate other tissues from her, such as kidney and endocrine glands. Routine skin exchanges may prove to be useful tests for tolerance to other tissues.—*Lyndon A. Peer, M.D.*, and *John C. Walker, Jr., M.D.*, St. Barnabas Medical Center, Newark, N. J.

Foam Mends Bone

Rigid Polyurethane Foam Used Successfully to Mend Fractures

A rigid polyurethane foam has been applied for fixation of bone in six human beings. One acute fracture of tibia, three non-unions (two of tibia, one supracondylar femoral), and two pathologic fractures of femurs were united by this substance.

Results in all cases have been satisfactory to date. The substance was well tolerated, and the strength of fixation was most gratifying.

In and during its formation, the foam, known as Ostamer, becomes an intimate part of the bone. It is this property that differentiates it from glue, adhesive, or common cement-type bonding.

(Continued on next page)

(L. to r.) William L. Estes, Jr., M.D., immediate past president, ACS; Paul R. Hawley, M.D., director, ACS; Isidore S. Ravdin, M.D., chairman, ACS Board of Regents; and Loyal Davis, M.D., editor, "Surgery, Obstetrics and Gynecology," celebrate Dr. Ravdin's birthday with a cake and all the trimmings during 44th annual ACS clinical congress.

ACS continued

The use of Ostamer is best restricted to those anatomical regions in which adequate hemostasis may be secured, by tourniquet or other established technic. Sufficient fixation for wound closure occurs in 20 to 30 minutes. Complete hardening requires 18 to 24 hours, after which stability of the bonded area is such that weight-bearing may be initiated.

Extensive studies are being made on toxicity, pharmacology, pathology, and carcinogenicity of the foam.—*Michael P. Mandarino, M.D.*, and *Joseph E. Salvatore, M.D.*, department of surgery, Hahnemann Medical College and Hospital, Philadelphia.

Auxiliary Heart

Reports Good Results Using Diaphragm as Auxiliary Myocardium

Experiments have been performed in experimental animals to study the effectiveness of the diaphragm as an auxiliary myocardium.

In two groups of experiments on dogs, the diaphragm was divided in the midline and the left half dissected from its attachments. Its major blood supply and the left phrenic nerve were not disturbed.

In the first group, the diaphragm was then wrapped around the heart so that the fibers ran transversely to the long axis of the ventricles. A transistorized electronic circuit was devised to pick up the QRS of the electrocardiogram and to deliver a stimulus to the left phrenic nerve throughout systole.

In the second group, the diaphragm was wrapped around the distal portion of the thoracic aorta. The electronic circuit was arranged to deliver a stimulus to the left phrenic nerve during systole.

Measurements of arterial pressures and flows revealed that the "auxiliary heart" added energy toward propelling the arterial blood peripherally. This resulted in conservation of the myocardium by diminishing the work demanded of it.—*Adrian Kantrowitz, M.D.*, and *William McKinnon, M.D.*, departments of surgery, Maimonides Hospital, Brooklyn, and State University of New York College of Medicine at New York City.

Small-Capacity Oxygenator

A small-capacity pump-oxygenator has been developed which can be functioning within 10 minutes. The unit consists of a disposable plastic bubble oxygenator with a 500-ml. priming volume and flow rates of 3,000 to 4,000 ml. per minute, and the standard Sigmamotor pump.

It is kept on a rolling table on the operating floor. When a cardiac arrest occurs, routine therapy is begun, and the femoral vessels on one side are exposed. Cannulation is then performed.

Meanwhile, the oxygenator is filled with 500 ml. dextran or O-negative blood constantly available for this purpose. Perfusion can thus be begun within 10 minutes.—*M. Martin Halley, M.D., Dennis M. L. Rosenberg, M.D., Ralph Ryan, M.D.*, and *Oscar Creech, Jr., M.D.*, department of surgery, Tulane University School of Medicine, New Orleans.

Finding Hemorrhage

String Test Developed as Aid To Localizing GI Hemorrhage

A modification of the string test utilizing fluorescein dye and a thin umbilical tape imprinted with radiopaque markers has been developed as a supplemental method of localizing the site of upper gastrointestinal hemorrhage.

The need for such a test is evident when it is realized that even with use of all clinical, laboratory, and radiographic tests available, bleeding cannot be localized in 15-20 percent of cases of such hemorrhage.

The string is swallowed by the patient and a flat film of the abdomen obtained two hours later to determine the string's location. After the string has passed the ligament of Treitz and it is apparent that the patient is having active bleeding, fluorescein is injected intravenously and the string withdrawn two minutes later.

Examination under an ultraviolet light may disclose whether active bleeding is occurring at the time of the test and can demonstrate the point of origin of hemorrhage when fluorescein marking has taken place. The place at which dye occurs on the string is marked with its comparable location in the x-ray film.

This test has been used in over 40 cases with no untoward complications.—*Mitchell Karlan, M.D.*, and *Donald W. Traphagen, M.D.*, department of surgery, Ohio State University College of Medicine, Columbus.

Arterial Grafts

Crimped Grafts Found More Elastic, Easier to Implant; Stay Patent

Crimping of dacron arterial prostheses makes them much more elastic and easier to implant.

When the dacron tube is placed on a smooth metal mandrel, it can be compressed longitudinally to form very fine crimps. Application of heat at a submelting point level makes the crimps permanent. They remain through washing, autoclaving, and wetting with blood at the operating table.

All prostheses were found to have longitudinal elasticity and a strong tendency to remain expanded in round form. Bending to more than 90° and even twisting at the rate of one turn for each eight inches was accomplished without kinking.

Of the first 24 flat dacron grafts inserted, 20 were successful. Of the first 36 crimped grafts, all 36 were successful. The crimped tube is easier to implant because of its round, open end and the greater latitude in length permissible because of its longitudinal elasticity.

All crimped tubes remained patent as compared to 65 percent of flat tubes.—*Ormand C. Julian, M.D., H. H. Su, M.D., Sa'd El Issa, M.D., Andre Lima, M.D.,* and *M. Lopez-Belio, M.D.,* department of surgery, University of Illinois College of Medicine, Chicago.

Hyperventilation

Inaccurate Monitoring of Oxygenators May Be Factor in Anoxia

Hyperventilation, hypocapnia, and respiratory alkalosis may result from the use of inaccurately monitored mechanical respirators or pump-oxygenators. These conditions may then produce tissue anoxia even in the presence of highly oxygenated blood.

Monitoring of pump-oxygenators should therefore include a pH or blood CO_2-analyzing device. Contrariwise, determination of the oxygen content of the venous return from the patient may give indirect evidence of the state of tissue oxygenation.

Bohr in 1904 showed that alkaline hemoglobin resists the release of bound oxygen. Our experiments have shown that the cerebral tissue anoxia resulting from hyperventilation is due mainly to the Bohn effect and only in a small degree to cerebral vasoconstriction.—*Capt. William G. Malette, M.D.,* MC, U.S. Air Force, department of surgery, VA Hospital, and the University of Colorado School of Medicine, Denver.

Hypothermia

Cerebral Injury Counteracted By Use of Hypothermia

Hypothermia has been found to reduce cerebral edema, and has been successfully used in four patients with severe cerebral injury following cardiac resuscitation.

To evaluate our observation, we conducted experiments in animals. Twenty-six animals were subjected to 10 minutes of circulatory occlusion. All developed severe central nervous system injury as evidenced by coma, lack of response to painful stimuli, dilated pupils, and slow, deep respirations.

Of the 12 in the control group, nine died in eight to 30 hours. Three survived, although one was blind. The survival rate was 25 percent.

The other 14 animals were treated with hypothermia for 18 to 36 hours. Three died. Eleven, however, showed a gradual recovery from the neurological injury over a 24- to 36-hour period. Three of the 11 later developed fatal respiratory complications, but the other eight survived without detectable signs of neurological injury.

The over-all survival rate, therefore, was 57 percent, but the recovery rate from neurological injury was 79 percent.

The exact mechanism of the beneficial effects of hypothermia has not been demonstrated. It may be than hypothermia decreases the amount of cerebral edema that results from cerebral injury from anoxia.

If this explanation is correct, hypothermia may be more beneficial when begun immediately after the cerebral injury than when begun hours later, when edema has already developed.—*Jack M. Zimmerman, M.D.,* and *Frank C. Spencer, M.D.,* department of surgery, Johns Hopkins University School of Medicine, Baltimore, Md.

Newell W. Philpott, M.D. (r.), Montreal, Que., Canada, is congratulated as he assumes presidency of ACS by outgoing president, William L. Estes, Jr., M.D., Bethlehem, Pa.

Ambulance Attendants

Doctors Must Assume Responsibility For Better Immediate Care of Injured

The medical profession must assume responsibility for improving the quality of immediate care of the injured.

Substandard management results when ambulance attendants are poorly trained or untrained. A survey by the American College of Surgeons committee on trauma showed "fair to poor" quality of transportation of the injured in 28 of 62 cities.

Attendants should be required to study 20 or 30 hours before they are permitted to render emergency service. They should then be obliged to take some special course of instruction. They should be examined yearly and be required to carry certification cards indicating their proficiency.

Ambulances should be inspected twice yearly.

Speed is not necessary to save lives. An ambulance averaging 30 miles an hour travels five miles in 10 minutes. At 60 miles an hour only five

(Continued on next page)

minutes would be saved. In 2,500 consecutive ambulance runs in Flint, Mich., this time interval would not have influenced the course of a single injury.

In 1.8 percent of cases expeditious handling was considered necessary, but a speeding ambulance could have increased the severity of the injuries.—*George J. Curry, M.D.*, chief, section for surgery of trauma, Hurley Hospital, Flint, Mich.

Cancer Studies

Method Localizes Effect of Nitrogen Mustard in Pelvic Area

Balloon-catheter occlusion of the distal aorta and inferior vena cava has been utilized in animals to preferentially localize the effect of intra-arterial perfusion of nitrogen mustard in the pelvic area.

Double-lumen balloon catheters were placed in the aorta and inferior vena cava above the respective bifurcations, and a concentration of 2 mg. percent of nitrogen mustard was perfused five minutes at a rate of 10 ml./kg./minute. The system was then flushed.

A reproducible high level of cytotoxic drug concentration in the localized area was obtained. Systemic toxic effects have been judged minimal.

The technic appears to offer a safe and simple method for delivering cytotoxic agents to malignancy in this area in concentrations six to 10 times as great as can be achieved by conventional means of administration.—*William M. Parkins, Ph.D., Robert G. Ravdin, M.D.*, and *Peter F. Coggins III, M.D.*, Harrison Department of Surgical Research, Schools of Medicine, University of Pennsylvania, Philadelphia.

Nitrogen Mustard Not Carcinogenic

Nitrogen mustard, when used clinically as a surgical adjuvant, does not appear to be carcinogenic, we have concluded on the basis of a series of experiments on rats.

Repeated clinical dosage levels of nitrogen mustard were administered to a group of 180 rats over a nine-month period, or as long as the animals could tolerate this procedure. Another group of 180 animals received repeated injections in levels two and one-half times the human clinical dosage. A third group served as control animals.

The control group developed tumors in approximately the same incidence as the animals which received both large and human clinical dosage levels.—*Gerald O. McDonald, M.D.*, department of surgery, University of Illinois College of Medicine, Chicago.

Technic Isolates Cancer Cells in Blood

A new technic has been devised to isolate and identify tumor cells in the blood stream. The blood specimen is centrifuged and the plasma aspirated. The cell pack is then washed, resuspended, and incubated with streptolysin O, a product of the streptococcus, which effects lysis of red cells and polymorphs.

The residual cells, consisting of lymphocytes and tumor cells, are resuspended and filtered through a Millipore filter. The cells are trapped on the filter and are stained there with the Papanicolaou technic. Cytologic identification follows.

A study is in progress to correlate the presence of cancer cells in the blood with the biologic behavior of the tumor and the patient's clinical course.—*John F. Potter, M.D.*, and *Richard A. Malmgren, M.D.*, surgery and pathologic anatomy branches, National Cancer Institute, National Institutes of Health, Bethesda, Md.

Inoculation Against Tumor

The course of malignant disease caused by implanted tumor in a susceptible animal may be altered by inoculation with homologous immune serum and homologous immune lymphocytes from animals which have successfully repressed the cells, we believe, on the basis of animal experiments.

These agents reduced the mortality following intraperitoneal inoculation of Bagg's lymphosarcoma in rats.

Nitrogen mustard in total doses of 0.8 to 1.2 mg./kg. produced a similar therapeutic effect.—*Frederick W. Preston, M.D., George C. Henegar, M.D., Elizabeth Jane Jackson, B.A.*, and *Robert Schrek, M.D.*, departments of surgery, Northwestern University Medical School and VA Research Hospital, Chicago.

Anticancer Drugs May Bring More Harm Than Good

Until more effective nontoxic cancer chemotherapeutic agents are found, anticancer drugs must be used cautiously, lest more harm than good results.

Patients given toxic cancer chemotherapeutic compounds may develop an accelerated tumor growth rate if the agent is ineffective against the tumor. In experiments in mice, injection of Ehrlich tumor cells and subsequent treatment with compounds having little effect on this tumor resulted in an increased number of metastases.

Treatment with anticancer compounds before tumor cell injection also resulted in accelerated tumor growth, presumably by reduction of host resistance.

Pretreatment of mice with chemotherapeutic agents increased the transplantability of a minimal number of tumor cells.

Our studies confirmed previous observations that cortisone-prepared animals developed a greater number of metastases, an accelerated tumor-growth rate, and increased transplantability.—*Tatsuhei Kondo, M.D.*, and *George E. Moore, M.D.*, department of surgery, Roswell Park Memorial Institute, Buffalo, N. Y.

William A. Mackey, M.D. (center), Glasgow, Scotland, and Hiroshi Miyake, M.D. (r.), Fukuoka, Japan, receive congratulations on their selection as honorary fellows of ACS, from George C. Adie, M.D. (l.), New Rochelle, N.Y.; Angus D. McLachlin, M.D. (second from left), London, Ont., Canada; and Grover C. Penberthy, M.D., Detroit.

Cortisone for Shock

Large IV Cortisone Injection Relieves Shock if Given Quickly

A single large intravenous injection of cortisone, if given within 30 minutes after the induction of severe hemorrhagic shock, will return the blood pressure to near normal ranges and maintain it there for several hours, we found in experiments on animals.

Once hemorrhagic hypotension below 50 mm. Hg. has been allowed to exist uncorrected longer than 45 minutes, however, a state of irreversibility has been reached, as far as hydrocortisone's effect is concerned.

We believe that in cases of severe hemorrhage, immediate replacement of the blood lost should be attempted. However, if blood is not immediately available or the hypotension does not respond to its administration, a large dose of hydrocortisone (100-200 mgms.) should be given intravenously within 30 minutes after the hypotensive state has begun.—*John E. Connolly, M.D., David L. Bruns, M.D.,* and *Raymond Stofer, D.V.M.,* surgical research laboratory, Stanford University School of Medicine, San Francisco.

Wet Linen

Three Drape Layers More Protection Against Passage of Bacteria

Two layers of wet surgical linen are unlikely to prevent passage of bacteria to the surgical field, but three layers offer substantially greater protection, we found in a study to evaluate the permeability of wet drapes to *Staphylococcus aureus.*

Other materials tested—a very finely woven material and standard multilayered paper—are significantly more resistant than ordinary drape material to passage of bacteria and are an effective barrier.

Seventy-nine experiments have been performed to date. Various thicknesses of sterile dry material fastened over the end of a glass tube have been immersed in a flask of sterile water after a known number of staphylococci were placed on the drape surface facing the inside of the tube.

Counting the number of organisms in the water after one hour gives an estimation of the permeability of the material to bacteria.—*Karl E. Karlson, M.D., William Riley, M.S.,* and *Clarence Dennis, M.D.,* department of surgery, State University of New York College of Medicine, New York City.

Hydrocephalus Treatment

10 Infants Treated by Draining Excess Fluid into Gallbladder

Draining excess fluid into the gallbladder is suggested as a method of treating hydrocephalus.

Studies in animals and on humans show that the gallbladder is biologically suited to continually receive, absorb, and conduct cerebrospinal fluid over long periods without evidence of electrolyte imbalance.

A bicuspid valve with one-way flow, made from lucite and polyethylene, was designed to prevent the reflux of bile. This valve is relatively durable and can withstand the application of bile over long periods.

Four of 10 patients treated with such a shunt died. All were in advanced stages of hydrocephalus. However, postmortem examinations showed the valves functioning in each. No patient developed electrolyte imbalance, gallbladder infection, or biliary dysfunction.—*George W. Smith, M.D., William H. Moretz, M.D.,* and *William Pritchard, M.D.,* division of neurological surgery, Medical College of Georgia, Augusta.

Fluid Drained into Isolated Ileum Segment of Infant

Hydrocephalus has been treated in one infant by draining the excess fluid into an isolated segment of ileum.

When the child was seven months of age, a segment of ileum four inches long was removed from the intestinal tract, the continuity of which was re-established by appropriate anastomosis. The segment, nourished via its mesentery, was caused to lie upon the paravertebral musculature as a closed loop. One month later, one end of the segment was

(Continued on next page)

sutured to an opening in the dura and arachnoid to permit the cerebrospinal fluid to have access to the ileal mucosa.

The head had enlarged progressively to 59 cm. by the day of this operative stage. Within two days, this measurement had decreased to 56.5 cm. For 10 months, the measurement has remained virtually constant, and is now 58.5 cm. Since the cerebrospinal fluid is contained in a closed system, it is predicated that it is being absorbed by the ileal mucosa in sufficient amount to maintain the cerebrospinal fluid pressure in normal range.

The child's physiological development seems to have progressed much more satisfactorily than would have reasonably been anticipated, had surgery been withheld.—*Charles G. Neumann, M.D., Thomas I. Hoen, M.D.,* and *Donald A. Davis, M.D.,* departments of surgery and neurosurgery, New York University Post-Graduate Medical School, New York City.

LeRoy E. Burney, M.D. (l.), Surgeon General, U.S. Public Health Service, discusses the 13th Martin Memorial Lecture, which he delivered at the congress, with Paul R. Hawley, M.D., director, ACS.

Use of Aortography

Study of Renal Artery May Show Defects Which Cause Hypertension

Defects of the renal artery are being discovered in increasing numbers as the cause of certain cases of hypertension. Even more would be detected but for the hesitancy of many physicians to use aortography in diagnosis.

This reluctance is understandable in view of the highly publicized, although infrequent, serious sequelae and occasional legal entanglements that may follow aortography. Yet, the importance of discovering these arterial defects is emphasized by the number of individuals who have been cured or relieved of potentially fatal hypertensive disease by appropriate surgical intervention.

Any abnormal kidney tracing calls for a complete x-ray of the artery to confirm the finding and outline the defect. An external radioisotope test may be used as a rapid screening device. A gamma ray scintillation detector and recorder will reveal the blood flow through the artery and determine its functional status.—*Chester C. Winter, M.D.,* department of surgery, University of California School of Medicine at Los Angeles.

Artery Clamp

Hydraulic Clamp Developed for Control Of Blood Flow in Brain Surgery

A hydraulic arterial clamp has been developed to provide better control of cerebral blood flow during intracranial arterial surgery.

The essential parts consist of a polyethylene holder shaped like a hollowed-out wheel, cut almost through diametrically and having one or two deep circumferential grooves on its external surface, and an inflatable latex, open-type collar molded in one piece to a 25-cm. tube ending in a "V."

The collar fits snugly into the hollow of the holder. Holder and collar are slipped about an artery, and the holder is closed with steel wire tied securely in the external groove. One of the "V" endings is connected to a syringe containing sterile saline and a small quantity of radiopaque material. The other end is connected to a manometer, or simply closed. The desired degree of occlusion can be produced by increasing or decreasing fluid pressure in the collar.

The clamp has been used successfully in 10 dogs and four humans. It seems applicable in cases requiring gradual occlusion of the carotid artery prior to subsequent ligation for cerebral aneurysm.—*Robert J. White, M.D., Alfred Uihlein, M.D.,* and *John H. Grindley, M.D.,* Mayo Clinic and Mayo Foundation, Rochester, Minn.

Cardiac Arrest

Says Cardiac Arrest May Result From Excess Oxygen During Anesthesia

The apparent increasing incidence of cardiac arrest, despite improved anesthetic technics, may be due in part to administration of too much oxygen during anesthesia.

Studies in animals suggested that oxygen saturation in excess of 25 percent might be detrimental. Prolonged administration of oxygen-enriched air brought about marked changes in arterial blood studies, and, in fact, instances of cardiac arrest in what appeared to be a healthy myocardium.

The animals were placed under barbiturate anesthesia. As the oxygen concentration was increased, there was an elevation of carbon dioxide in the blood, along with electrocardiographic instability.

Changes occurring with volatile anesthetics follow the same trend but are not as marked as those occurring with barbiturate anesthesia. Studies are being continued.—*Sam E. Stephenson, Jr., M.D.,* S. R. Light Laboratory for Surgical Research, and departments of surgery and pediatrics, Vanderbilt University School of Medicine, Nashville, Tenn.

Indiana Hospital Association--

Indianapolis, October 8-9

• The thirty-seventh annual IHA convention, held at the Indiana University Medical Center, was attended by over 100 representatives from hospitals throughout the state. Among matters of business reported as accomplished during the past year were: establishment of Mutual Hospital Collection Service, Inc., for the collection of poor accounts for subscribing hospitals; stabilization of salary schedules; inclusion of Indianapolis hospitals in the civilian defense setup of the city; and standardization of visiting hours in all hospitals throughout the entire state.

At left, Emery K. Zimmerman (r.), honorary president-elect, Indiana Hospital Association, and Olive M. Murphy, R.N. (right picture), president, receive plaques in recognition of their outstanding service to the association. Both presentations were made by Albert G. Hahn, L.H.D., executive secretary.

Home from the Hospital

Infants Transmit Nursery Staph Infections to Family Group

We are now beginning to understand that the term staphylococci covers a huge group of organisms; and even within the group, we are familiar with marked differences in their ability to cause disease. Much of the increases in staphylococcic disease is more apparent than real; it was there previously, but now we have the technics and the understanding to bring it into the spotlight.

We have followed two lines of research. The first began 10 or 12 years ago, when staphylococci developed a resistance to penicillin, then to other antibiotics. The hospital is a tremendous producer of resistant strains, which tend to remain on the skin and in the nasal passages of discharged patients, and are subsequently transmitted to the home.

Our interest in the second line of inquiry was spurred by the outbreaks, in newborn nurseries, of staphylococci of high reproductive or epidemic ability. Such outbreaks are due to one strain of staph—an epidemic strain. Such a strain is usually introduced into the nursery by a carrier who may, through a break in technic, cause skin infections in infants. This is an occasional, usually not so serious, outbreak.

A real, uncontrolled epidemic becomes apparent when mothers come back to the hospital with breast abscesses, and the infants are admitted to the pediatrics department with skin or deep abscesses. Breast abscesses now occur in as many as 10 to 15 percent of infants born during epidemic periods. The vast majority of infants affected do not develop lesions while in the hospital; 10 times as many infants develop abscesses after they return home.

We need surveillance of patients after discharge. Otherwise, an epidemic may go on uncontrolled in the hospital for weeks or months.

Twenty percent of the infants do not develop lesions, but carry them. Of the infants affected, 75 percent transmit the infection to the mother; 30 to 40 percent of nursing mothers develop breast abscesses.

Staph infection may persist in a family group for years. Of 26 families studied for six months, 11 retained a positive reaction. One family of five has never been free of infection since the birth of an infant in 1954.

(Continued on next page)

From left: E. O. Scales and Charles E. Lebo, both of Aetna Casualty and Surety Co., speakers at the convention, discuss hospital liability insurance with Franklin Simek, vice-president, and Arthur S. Malasto, president, County Hospital Section, IHA.

From left are: Helen Boyer, administrator, Dunn Memorial Hospital, Bedford; Lula F. Martin, dietitian, Gibson General Hospital, Princeton; Jane Mahon, student nurse, Indiana University; Vera Mahon, business manager, Gibson General Hospital; and Mrs. Albert G. Hahn, assistant administrator, Protestant Deaconess Hospital, Evansville.

Above: Broad smiles were nominated and elected to preside at the reception at the Sheraton-Lincoln Hotel, Indianapolis. Setting the pace, above, are Everett A. Johnson, president-elect; Olive M. Murphy, R.N., outgoing president; and Albert L. Boulenger, incoming-president; all of the Indiana Hospital Association.

F. D. Dober, business manager; Geraldine Mellon, director of nurses; and Elizabeth Gleasure, R.N., all of Dearborn County Hospital, Lawrenceburg, dispense with business in favor of a social chat.

Below: Peter Mariana, resident, and Betty Westendorf, director of dietitics, Community Hospital, Indianapolis; and Lou Alice Arbogast, hospital nurse consultant, and Delbert Bouck, administrative consultant, Indiana State Board of Health.

INDIANA continued

We know less about the incidence of staph infection in the surgical and medical departments. Usually we are not confronted with an explosive outbreak, but rather, a slow and steady increase in post-surgical abscesses. Surgeons say one percent is expected; 15 percent is not unusual.

From the experience of our group in 25 epidemics, I would say one of our first problems is that of communication. We have so departmentalized our hospitals that each is aware only of what goes on in its own department. Each holds its own meetings; thus, pediatrics may be totally unaware that an epidemic in the nursery is responsible for a number of the patients being admitted to pediatrics. Too, some hospitals with nurseries have no pediatrics department, so the patient takes his infection to a different hospital.

We need not only better communication within our hospitals, but between the hospitals and the health department. Several years ago there was a real desire to hide staphylococcic infections, because of guilt reactions among the staff. We are gradually tending to share our troubles, and our knowledge.

We have a lot to learn, too, about environment and transmission. And we need to know more before we accept expensive, sweeping changes. We are currently being bombarded with ideas about air-conditioning and ventilating. Thus, we have a tendency to buy a ventilating system instead of convincing the chief of surgery to wear his mask over his nose instead of over his upper lip.—*Frederick H. Wentworth, M.D.*, medical coordinator of disease control activities, State Department of Health, Columbus, O.

James White, assistant administrator, Memorial Hospital, South Bend; Mrs. E. K. Zimmerman; E. K. Zimmerman, administrator, Elkhart General Hospital; and Ethel Jacobs, president, Indiana League of Nursing, enjoy reception and buffet put on for conventioneers by Mead Johnson & Co.

Hoosier Hospital Harmony was supplied by Indiana University students through the courtesy of 16 manufacturers in the drug and hospital fields. The young ladies and gentlemen sang and played for an audience that would have liked to keep them on-stage indefinitely.

Q. Are we so thorough in cleaning up the newborn that we remove its protection before the infant has a chance to build natural antibodies?

DR. WENTWORTH: My own opinion is that an antiseptic bath, immediately after birth, is sound practice. Hexachlorophene will interrupt and cut in half the incidence of skin infections, and reduce the number of nasal carriers.

Q. What do we do about personnel carriers?

DR. WENTWORTH: If their infection is of a transient nature, we eliminate only the infection. Permanent carriers are, themselves, permanently eliminated from the nursery—but don't ask me where to put them, please.

Q. Should masks be worn in the nursery?

DR. WENTWORTH: There are different views. My own is that masks, as we use them, are lethal instruments. We trap organisms in wet, soggy masks, through which we then talk and sneeze.

Q. Do medical records have a place in controlling infection?

DR. WENTWORTH: Definitely. We must have some kind of reporting from the records library or from the service itself. An infection log should be kept, and a report on discharges made to a central infections committee.

Bigger Umbrella

Three-Fold Insurance Coverage Increasingly Vital to Hospitals

Insurance, being an intangible product, often is not given full attention by hospitals until they find themselves named in a suit or claim. Premises protection, formerly considered all-important, is currently part of a three-fold protection, the others being professional and malpractice insurance.

The matter of protection limits formerly was not a matter of primary concern, because few suits were presented. Now, with the trend away from immunity, and with the public change of attitude towards damage suits, coverage from $50,000 to $100,000 is not unusual.

Another consideration which should encourage a long-range review of coverage is the fact that cases often are not instituted until long after the incident, often just prior to the date of statutory limitation. One instance concerned a hospital which carried $50,000 insurance. A 2-year-old child was burned by a hot water bottle placed between its legs following an operation. Suit was brought years later, and the plaintiff was awarded $75,000—$25,000 more than the hospital's insurance coverage.

A man, admitted for chest pain, and considered an ideal patient, was found sitting up in a chair smoking at 5 a.m. Rebuked, he threatened a nurse with a metal footstool, and subsequently jumped to his death from a window. The hospital, understandably perhaps, did not consider itself at fault. The court thought otherwise, and awarded his next of kin $13,262.

Cases such as these sometimes panic hospitals into seeking too high liability limits. But these can be as much of a financial millstone as too low limits are a hazard. Your own hospital or personal needs are best worked out with your insurance counsellor. Prior to 1952, Indiana had few malpractice experiences. Records were privately kept, so there was no basis for arriving at a standardization of rates. Now, however, we do have a rate structure which keeps abreast of trends, and varies in states according to experience.—*Charles E. Lebo*, assistant superintendent, underwriting department, and *E. O. Scales*, head of claims department, Aetna Casualty and Surety Co., Indianapolis.

Q. If a hospital feels it is not guilty of negligence in a case, but its insurance company suggests an out-of-court settlement, what is the basis for the company's recommendation, and what should be the hospital's decision?

MR. SCALES: Malpractice used to be a nasty word, to patients as well as to hospitals. Now that it has become socially acceptable, so to speak, we must consider several factors. Will the plaintiff be genuinely affected by the injury, and does his lawyer have sufficient evidence to prove it? Equally important is the jury. We know from experience that some jurors will overlook the lack of evidence of negligence if serious injury is evident, or arouses sympathy. In such a case, a settlement is advisable.

Q. Aren't we being penalized by people who are dissatisfied with results of their hospital stay?

MR. SCALES: Yes. The law still says that neither a hospital nor a doctor can guarantee good results, but there is, again, that subtle change in public thinking. From the time of infancy to old age, people have fallen out of bed, and climbed back in no worse for the experience. Now if it occurs in a hospital—a relative often has a lawyer on the phone before the patient hits the floor. Whether we settle or not depends on whether we think the lawyer can take the case to a jury.

Mrs. Kenneth Williamson and her husband join the fun at IHA reception. Mr. Williamson, director, Washington Service Bureau, American Hospital Association, spoke during convention on national legislation affecting hospitals.

The Patient-Nurse Communication

By James G. Harding*

• Many new concepts of nursing care undoubtedly will confront the hospital of the future. Even today, the need for rendering better patient care is placing ever-increasing demands on the hospital, particularly on the nursing staff. Thus, it is necessary to evaluate our services constantly, keeping in mind that there may be better ways to perform them.

Intercommunication systems between patients' rooms and nurses' stations have been in use for many years, although they were not popularly accepted by hospitals until the late Fred G. Carter, M.D., suggested a practical innovation. He conceived the idea of the dual-reset feature which automatically extinguished the light after the patient's call had been answered at the nurses' station. This modification made it possible, for the first time, to answer a patient's call without going to the bedside to reset the apparatus for the next call.

The audible-visible nurses' call system for hospitals was another substantial improvement. The major drawback to most such systems, however, is their cost—which includes both the cost of the equipment and its installation and the attendant disruption of communication service to patients while the system is being installed. Hence, not only is the cost of installing the system high, but the loss of revenue from beds during installation in an established hospital makes the expense almost prohibitive, budgetwise.

When the Cleveland Clinic's new hospital wing was built recently, an automatic type of audible-visible nurses' call system was installed. The installation of this automatic system was no particular problem, so far as the hospital was concerned, except in regard to cost—we were well aware that the installation would cost almost half as much as the equipment alone.

Of course, since this system was installed in a new building, one not yet occupied by patients, there was no disruption of patient service. But, at the time that the system was installed in the new wing, we did not proceed with the installation of a similar system in the nursing divisions already established in the hospital because of the high cost and the disruption of service.

Recently, however, a unique nurses' call system came to our attention, and we installed it in the hospital proper. This system is specially designed for installation in an already functioning hospital. It operates

*Superintendent, Cleveland (O.) Clinic Hospital.

Secretary (below) converses with patient through phone receiver; light at top of unit indicates call, light on panel locates patient by bed number. Nurse (left) can bring required equipment when answering call.

System of Tomorrow — Here Today

from the wiring already present in most hospitals which have a locked-button light-call annunciator system that has visual indication at the nurses' station.

This new system was installed by our own electricians; we estimate that its cost was from $600 to $1,000 cheaper than it would have been for any other conventional audible-visible system for a similar 50-station installation. This "do-it-yourself" system is so easily installed in the normal hospital that the electricians in most hospitals should be able to handle it.

The new system incorporates the desirable features of the automatic equipment we have in the new hospital wing. Also, the ward secretary is spared the effort of mastering the complicated operation of a talk-listen switch; she simply uses a conventional telephone handset to communicate with the patient. The patient's room is equipped with a wall speaker-microphone unit and a call switch which is activated by the patient. When the patient pulls the switch cord:

(a) A pilot light indicates to the patient that the call has been initiated.

(b) The numbered dome-light outside the room is lighted.

(c) A light on the master unit at the nursing station is lighted.

(d) Another light beneath the bed number on the master unit is lighted, which tells the ward clerk which patient has made the call so that she can then address him by name.

The secretary need only pick up the telephone receiver to converse with the patient. There is no need for her to press a button of any kind to talk, or to release one to listen. She can speak as she would in a normal telephone conversation.

As soon as the telephone has been replaced in its cradle, the next call may be received. If the ward secretary desires to contact a patient, she simply moves a toggle switch on the master panel to that particular patient's room number—and talks.

What allows her to do this is a transistorized amplifier. This modern-day development, we think, is one of the most important improvements made in an audible-visible nurses' call system. First of all, unlike a tube-powered amplifier which must be turned on all of the time, the new, transistor-powered amplifier need be on only when it is actually in use. The reason is that transistors, unlike tubes, need no "warming-up" time. They have an exceedingly long life span to begin with and, in this system, will last almost indefinitely since they are used only when the amplifier is turned on. Thus, transistor-powered amplifiers minimize the tube-replacement problem, also.

The transistorized amplifier is powered by two small batteries. These will operate the amplifier for at least a year of normal use at a cost of about one dollar. Battery operation makes possible emergency use of the new nurses' call system in case of power failure in the building, and allows the ward secretary to reassure patients when a power failure occurs. This feature, of course, also saves the expense of connecting the nurses' call system to the emergency power supply, as has been done with previous equipment.

While I have stressed the ease of installing this new system in our hospital, in which a locked-button light system previously had been in use, I can see advantage in the system for any type of installation. All that is required in the way of wiring is two common wires and one wire per station to each outlet.

Compared to this is the wiring required for previously used equipment: two individual wires and a pair of twisted wires per station, and three common wires to each outlet. The result, in the installation of the new system, is a considerable saving in wiring and conduit, as well as labor, costs.

Having had several years' experience with our previous automatic nurse-patient intercommunication system, then having installed and used this new type of system, we believe that the new version will take its place among the greatest contributions to patient care. Since the new system requires fewer wires, installation is so greatly simplified that every hospital bed can be equipped with it. With the current shortage of nursing personnel, this becomes almost as necessary and important to patient care as the hospital bed itself.

Patient pushes switch which lights pilot light in room, numbered dome-light outside room, lights on nursing station master unit.

Hospital Rides a Hobby Horse

• Hobby enthusiasts on the staff of Presbyterian-St. Luke's Hospital, Chicago, had the opportunity recently to show off their prize collections and art work when the institution opened its doors for hobby shows, put on by personnel in the two divisions. Judges awarded prize ribbons for the outstanding displays.

Attesting to the wide range of interests of the participants, the exhibits included examples of embroidery, crocheting, knitting, dressmaking, copper work, painting, jewelry, woodcarving, photography, Christmas decorations, toys, boat and train models, and miniature Japanese spoon gardens—all made or collected by hospital workers.

Pictured here are highlights from the 2-day show of the St. Luke's division staff. A similar show, held the following two days, displayed the hobbies of the Presbyterian division staff.

Above: Horses—even of the hobby variety—and guns belong together, so it was natural for Jerome Paul, M.D., medical staff, to enter his antique gun collection in the show. Jerald Jarrett, M.D., intern, examines .32 caliber Smith and Wesson revolver, which was used by officers in Civil War. One of the oldest guns in the collection is a .60 caliber Arabian flintlock pistol, circa 1750.

Left: Joseph Moreno, chef, explains process he used to make authentic tin replica of Aztec Indian mask to Elinor Dow, student nurse. Mr. Moreno, originally from Mexico, not only reproduces the artifacts but has done his own exploring, and has made a study of the Aztec way of life. Some of the relics he found near the Leotihuacan pyramids, Mexico, were made by Aztecs before the Spanish conquest.

Below, left: Mrs. R. M. Deansley (r) and Mrs. Charles Harvey, volunteers, admire detailed perfection of Japanese dolls, exhibited by Mrs. Rose Maeda. Dolls' dresses illustrate different costumes worn in Japan, including those of Geisha girls and peasant women.

Below, right: Boone Mora, pathology department, enjoys searching for interesting bits of driftwood which he sands, shellacks, and mounts. He also names the pieces he finishes.

How one hospital competently cared for victims of a train wreck, thanks to good planning

Preparedness Pays When Disaster Strikes

By Sister Miriam Thomas*

• Disasters, unfortunately, are no novelty to us at Good Samaritan. Our 127-bed hospital is located at a point in the foothills of the Ramapos which is quite near several major highways—Route 17, the New York State Thruway, the Palisades Interstate Parkway, and the New Jersey Turnpike. All of these regularly deliver into our hands the tragic consequences of speed, carelessness, and the impact of metal and glass upon living flesh.

This is certainly not a role to be cherished, but it has its compensations. We are thankful, on behalf of the 1,889 emergency accident patients we treated in 1957, that the skills and facilities represented by our hospital and the experience of our staff were on hand when they were so critically needed and that they probably succeeded in saving many lives that might otherwise have been lost.

We are also thankful that our constant awareness of danger hovering nearby has tended to sharpen our senses and has made us, I think, just a little better prepared to cope with sudden catastrophe than many hospitals our size.

So we were ready, on the morning of August 11, when two Erie Railroad commuter trains crashed head-on less than six miles from our door. The two Diesel locomotives came together and lifted slightly at the point of impact.

How did it happen? As always, because of a tragic combination of circumstances, any one of which alone would not have been enough to cause the accident. If the signalman had not been so busy when he got word that an eastbound train was temporarily moving onto a westbound track in order to overtake a freight . . . if he had not relied on his memory to pass the word along . . . if there had not been a "dead spot" which blanked out his tardy radio warning to both trains . . .

At first there could be comfort only in the thought that the accident might have been much worse if both trains had not slowed down just before they met, as they rounded a curve. The toll might have been much higher if the crash had taken place an hour later, when both trains would have been much more heavily loaded with commuters.

As it was, five people were killed immediately—three railroad employees and two passengers. Of the injured, 21 were eventually admitted to Good Samaritan.

(Continued on next page)

*Administrator, Good Samaritan Hospital, Suffern, N.Y.

Head-on collision of two New York commuter trains twisted metal like clay, killed five passengers.

The accident took place at 6:55 a.m. The first victims were in our emergency room at 7:20.

By the time the reporters started arriving, every one of the injured, except for two who were treated and sent home, was in a bed and under treatment. Although three cases were on the critical list, every single one recovered and was eventually discharged.

Journalists and crews from radio and television news units, starting to arrive soon after the crash, were astounded to find Pink Lady volunteers all set up in our corridors, serving coffee and sandwiches from our hospital kitchen (we do not yet have a cafeteria for guests). Detailed information for the news media was ready and waiting—including names of victims, extent of injuries, nature of treatment, and other data.

When I reflect on the quiet, efficient, and yet thoroughly warm and sympathetic manner in which our hospital personnel functioned that morning to relieve the pain and minister to the injuries of the victims and to comfort, reassure, and inform their families, their friends, and the press, I cannot suppress a quiet glow of satisfaction. I especially recall the remark of one of the incredulous reporters, made a few minutes after he arrived and someone asked him about the emergency.

Rescue workers remove victim by stretcher after commuter train crash in New York.

"Emergency?" he said. "What emergency? You'd think something like this happened here every day!"

And yet, it would be wholly out of character with both my secular and religious responsibilities if I gave the impression that the job we did on August 11 was the result entirely of superior management. This would not only be immodest—it would be untrue.

We in religious life, especially those of us in hospitals, recognize the fact that the Providence of God is always present. In this instance we feel that it was the Providence of God that provided the beds for the 13 patients admitted to "Male Hall." Normally under existing conditions five emergency patients would fill the department to capacity.

The time of the accident was in our favor. Many of our patients had checked out the day before, which was Sunday. Those scheduled to be admitted that Monday had not yet arrived. Our admitting office promptly went into action to take advantage of this circumstance, getting on the phone to doctors and patients, notifying them they would have to postpone scheduled operations.

We were fortunate, also, that when the first news of the disaster came over the radio, our night shift of workers had not yet left and our day shift had just come on. Of course, our nursing Sisters, whose cells are in a wing at the rear, are always available if needed quickly.

As soon as news of the accident got around, volunteer workers began to appear as though by magic. I remember walking into a ward and seeing a man I did not know performing a nursing chore for one of the patients. When I asked who he was, he explained that he was Joseph Du Ross, a male nurse employed in St. Mary's Hospital, just over the state line in Passaic, N.J. He had been driving home from his night shift, had heard a report of the accident on his car radio and decided he could be of help to us.

"Yes," I said, "you can help."

Later, I wrote him as follows:

"Our directress of nurses, Sister Joseph Rita, has told me of the generous and excellent nursing service you rendered to the injured at our hospital the day of the Erie Railroad accident.

"We are all deeply grateful to you for your help during this severe emergency. The response of people from both far and near was inspirational and truly in the Christian spirit.

"Again, thank you for your very fine service. May God bless you, and be assured you are in our daily prayers."

Nurses' aides and other volunteers headed for the hospital as soon as they heard what had happened.

Catherine Gallagher, R.N., supervisor of our emergency department, at 7:05 that morning phoned Dr. John C. Petrone, one of our directors, who lives about a quarter of a mile from the hospital.

"The police say they have a man hit by a train," she told him.

Dr. Petrone was at the hospital within minutes, ready and waiting by the time the first victims arrived at 7:20. As he tells it:

"Until we saw those first victims, we didn't even know there'd been a train wreck. As soon as we did, though, we sent out word that we would admit every victim. We alerted the x-ray lab and gave orders to get blood ready, because we had no idea how many would be coming in. Dr. Abraham Freudenheim, our radiologist, came over immediately to do the x-rays.

"From then on, everything went like clockwork. Ambulances kept arriving, unloading, and going back for more. Victims were immediately blood-typed and identified by adhesive tape on their wrists, on which we noted their names and treatment given. We figured we could get the additional details we needed for their admission later on.

"After shock therapy and other necessary immediate work was done, the patients were moved into an elevator we'd kept in readiness and were brought up to their waiting beds.

"One of the cases we spotted coming in was a dislocated cervical vertebra. Arm paralysis was the tip-off. We x-rayed immediately and started traction. I think we probably avoided paraplegia in that one. There were also profusely bleeding wounds, which were given emergency treatment, a ruptured spleen, a crushed chest, concussion, and long bone breaks."

This bulletin was issued the following day:

To All Good Samaritan Hospital Personnel

SPECIAL BULLETIN

Your excellent co-operation and assistance during the railroad emergency on Monday, in maintaining the hospital routine, under stress, enabled us to give hospital care to all the injured efficiently, calmly, and courteously.

My sincere thanks to all of you. I deeply appreciate your help.

Sister Miriam Thomas
Administrator

Later, we tried to sum up our experiences—Dr. Petrone, Nurse Gallagher, and I. What, in essence, does it take to handle an emergency like this with speed, efficiency, and humanity?

"It helps to have doctors on the staff with wartime experience," Dr. Petrone says. "After that, any civilian emergency is apt to be routine. The main thing is for somebody to take charge. It helps to have authority clearly designated, with a chain of command in case the top person isn't available.

"The hospital should have a plan. There should be meetings at regular intervals, talks with the staff, discussions of what to do—if and when. But keep the plan flexible. Iron-clad rules won't work.

"For instance, we know exactly where we can put any sudden overflow of patients. We're right across the road from Tagaste, the Augustine seminary. We know exactly how much space is available in the corridors of their building. We even know, to the minute, how long it would take us to move a patient there from our emergency room. This is the kind of information every hospital should have and every member of its staff should know about.

Newsmen mingle with onlookers at accident site. Journalists were amazed to find Good Samaritan had detailed information ready on victims it treated.

"Of course, it also helps to have extra supplies of mattresses. If necessary, they can be spread on floors. And one should keep plenty of oxygen available, along with other emergency treatment equipment. We're always well stocked, throughout the entire hospital, with such items as blood, blood substitutes, morphine and codeine (under lock and key, of course), antibiotics, and burn dressings. Above all, one should keep a constant, current roster of where everybody can be reached for every portion of the 24 hours.

"Keep your doctors *in* the hospital, we would advise. It's best if there's no more than one doctor on the scene of the disaster. With more than one there are apt to be conflicts of opinion about whom to treat first.

"In general, we'd say leave the on-the-scene work to the volunteer ambulance corps. Its members do a fine job. They are expert in giving first aid, applying tourniquets, determining the extent of crash injuries,

(Continued on next page)

THE ALL NEW
TERRELL RECTAL TABLE
IS THE ULTIMATE WORD IN
PROCTOLOGICAL EXAMINATION
—Motor Tilted—
ease and facility for the physician
safety and comfort for the patient
CIRCULAR UPON REQUEST
ON DISPLAY
HARRY WELLS
400 E. 59th St. N. Y. C. 22, N. Y.

ANCHOR *All-Nylon* SURGEON'S BRUSH

Tough... Guaranteed to withstand more than 400 autoclavings

Gentle...Tufts are soft but firm...specially tapered for better scrub-up efficacy with more comfort

Anchor Brushes weigh only 1½ oz. . . . grooved handles for firmer gripping . . . crimped bristles for better soap retention . . . designed for efficient use in Anchor's modern brush dispensers.

Anchor Brushes save money for you because of their unusual durability and outstanding performance. They are the most economical on the market today.

Order by the dozen or gross from your hospital supply firm . . . today!

Other outstanding Anchor Products...
the new All-Nylon Emesis Basins
All-Nylon Drinking Tumblers
Stainless Steel Surgeon's Brush Dispensers

Sold Only Through Selected Hospital Supply Firms

ANCHOR BRUSH COMPANY

AURORA, ILLINOIS

Write for Complete Information to Exclusive Sales Agent:

THE BARNS-ELY COMPANY

1414-A Merchandise Mart • Chicago 54, Illinois

and moving victims onto stretchers to avoid further injury. They practice that sort of thing all the time. From what I've seen, the volunteer ambulance corps people are excellent.

"One of the most important things a hospital can do in an emergency is to have an information service functioning. Prompt, complete, accurate information for anxious family, friends, and reporters keeps them out of the way—lets the doctors do their work."

Nurse Gallagher agrees. In the emergency room, she recommends the assignment of nurses who can make quick decisions under pressure, who know the value of obeying promptly the orders of the doctor.

"Emergency room nurses have to be even-tempered, fast-moving, diplomatic," she says. "And it helps for them to have a good, instinctive sense of public relations. You watch for these qualities and know where they are on the hospital staff. They're worth their weight in gold when the stretchers start coming in."

I listen to Dr. Petrone and Nurse Gallagher and all the others who helped us handle this crisis so well. I think of the fact that we were treating about 135 patients at the time, although theoretically we have a capacity of only 127 beds.

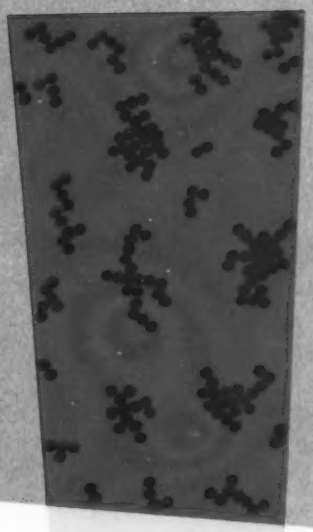
Nobody knows better than I that no hospital can compete, in wages, with private industry. This is especially true of Catholic hospitals, like Good Samaritan. But, happily, the kind of loyalty and self-sacrifice displayed by our staff on August 11 is something money cannot buy.

But money *can* buy the expanded facilities we hope to provide with a new east wing, offering a greater hospital to more people in the area we serve. It is perhaps typical of our hospital that our medical staff pledged itself to raise 20 percent of the $500,000 we shall need in community contributions in order to pay for the new construction and that 90 percent of the 20 percent has already been raised.

With such an example before them, and the memory of the role we played in the recent Erie Railroad disaster, as well as so many others, over the past half-century, I am confident the support necessary for our expansion program will be forthcoming in generous measure.

What do you suppose he means by "Whoops!"?

NOW—*the first-choice antibiotic for any staph infection*



KANTREX®

Kanamycin Sulfate

Clinically proven bactericidal antibiotic providing:

- ***Bactericidal*—not merely bacteriostatic—action**
- **Wide antimicrobial range...even against many heretofore resistant organisms**
- **Rapid effect**
- **High serum levels**

—"leaves the least for the host to do"

Bristol

For rapid bactericidal action in any staph infection...

KANTREX®

Kanamycin Sulfate

"The rapidity with which bacteria are killed by this agent (KANTREX) is reflected by the promptness of the clinical response."[11]

SUMMARY OF CLINICAL RESULTS WITH INTRAMUSCULAR KANTREX—

DISEASE	NUMBER OF PATIENTS	GOOD RESULTS	FAIR RESULTS	INDETERMINATE	NO IMPROVEMENT
Respiratory tract diseases [1, 2, 3, 6, 8, 11, 12, 14, 15]	77	55	6	4	12
Urinary tract diseases [1, 2, 3, 4, 6, 7, 8, 9, 11, 13, 14]	204	148	—	5	51
Soft tissue infections [1, 2, 3, 5, 8, 11, 12, 13, 14, 15]	177	153	5	4	15
Septicemia [1, 6, 11, 12, 14, 15]	30	18	2	1	9
Osteomyelitis [1, 2, 8, 11, 13, 14, 15]	15	9	—	2	4
Bacterial endocarditis [1, 3, 6, 10, 14]	8	4	2	—	2
Miscellaneous diseases [2, 3, 6, 8, 11, 12, 13, 14, 15]	48	30	6	3	9

— IN 559 CASES REPORTED BY 31 INVESTIGATORS

Indications: Indications for KANTREX include infections due to kanamycin-susceptible organisms, even many of those resistant to other antibiotics:

Respiratory tract infections: Tracheitis, bronchitis, pneumonitis, bronchopneumonia, lung abscess, pleuritis, empyema, and bronchiectasis.

Urinary tract infections: Acute and chronic pyelonephritis, and cystitis.

Soft tissue infections: Wound infections, abscesses, cellulitis.

Blood stream infections.

Osteomyelitis.

Dosage: Adults: Average daily intramuscular dose 1 to 2 Gm. in 2 to 4 equally divided doses.

Children: Average daily intramuscular dose 15 to 30 mg. per Kg. in 2 to 4 equally divided doses.

Precaution:

Skin eruptions and signs of renal irritation (which disappeared on cessation of therapy) have been occasionally noted. In a few cases, signs of eighth nerve dysfunction (tinnitus, vertigo, loss of hearing) have been observed: (1) in patients with pre-existing renal insufficiency, (2) in patients receiving 18 Gm. or more of KANTREX, and (3) in patients over 45 years of age. Animal studies indicate that KANTREX has less auditory toxic potential than dihydrostreptomycin.

Supply: Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

KANTREX (kanamycin sulfate) 0.5 Gm. in 2 ml. volume.

KANTREX (kanamycin sulfate) 1.0 Gm. in 3 ml. volume.

Kantrex Sensitivity Discs and comprehensive literature available on request.

References: **1.** Bunn, P., Baltch, A., and Krajnyak, O., State University of New York Upstate Medical School, Syracuse, N.Y.: Annals N.Y. Acad. Sci. In press. **2.** Cronk, G. A., and Naumann, D. E., Dept. of Health and Preventive Medicine, Syracuse University, Syracuse, N. Y. *Ibid.* **3.** Davies, F. G., Marcy State Hospital, Marcy, N.Y. *Ibid.* **4.** Dube, A. H., Edward S. Van Duyn Memorial County Hospital, Onondaga, N.Y. *Ibid.* **5.** Finegold, S. M., Winfield, M. E., Aronsohn, R. B., Hewitt, W. L., and Guze, L. B., University of California Medical School, Los Angeles, Calif. *Ibid.* **6.** Greey, P. H., and Wightman, K. J. R., University of Toronto, Toronto, Can. *Ibid.* **7.** Herrold, R. D., and Karabatsos, N., College of Medicine, University of Illinois, Chicago. *Ibid.* **8.** High, R. H., Sarria, A., and Huang, N. N., Temple University School of Medicine, Philadelphia. *Ibid.* **9.** Ichikawa, T., Medical Faculty, University of Tokyo, Tokyo, Japan. *Ibid.* **10.** Katz, S., District of Columbia General Hospital, Washington, D.C.: Personal communication. **11.** Rutenburg, A. M., Koota, G. M., and Schweinburg, F. B., Harvard Medical School, Boston: Annals N.Y. Acad. Sci. In press. **12.** Ruiz Sanchez, F., and Ruiz Sanchez, A., University of Guadalajara, Jalisco, Mexico. *Ibid.* **13.** White, A., and Knight, V., School of Medicine, Vanderbilt University, Nashville, Tenn. *Ibid.* **14.** Yow, E. M., and Monzon, O. T., Baylor University College of Medicine, Houston, Tex. *Ibid.* **15.** Yow, M. E., and Womack, G. K., Baylor University College of Medicine, Houston, Tex. *Ibid.*

Bristol LABORATORIES INC.
SYRACUSE, NEW YORK

A report from Lebanon

Medical Care Under the Guns

Administrator Richard E. Sawyer stands in driveway of hospital in Beirut. Sign, in Arabic and English, advertises gift shop, project of Women's Auxiliary.

By Richard E. Sawyer*

• On an otherwise ordinary Thursday, the morning newspaper carried a story of the assassination of a newspaper editor noted for his critical attitude toward the incumbent government. A call was made for a general anti-government strike.

Soon guns were used, barricades were erected to cut off parts of the city, and businessmen remaining open were persuaded to close their doors by explosions in the market places. Streetcar services were discontinued after one car exploded, and a Pepsi-Cola truck erupted in flames in a shopping center. Nightly curfew was imposed from dusk to dawn.

Under circumstances such as these, how does a hospital operate? These are some of the problems faced in the past few months by the American University Hospital, Beirut, Lebanon. Through the ups and downs of the crisis, as in other crises in the past, operations have been at or near normal levels most of the time, although at the expense of frayed nerves and a great deal of effort on occasions.

After the editor's assassination on May 8, 1958, newspapers suspended publication for three days, and reliable news was nonexistent. Rumors of developing trouble became more frequent, and reports from the north indicated serious rioting. A call was made for a three-day general strike in Beirut and other major cities, which was fairly effective for those days. Transportation was not interrupted, however, and public utilities continued to function.

The following Monday the situation appeared to be no better, and merchants were being exhorted to continue the strike. In the souks, the centrally located markets in which many of the hospital's food suppliers make their purchases, bombs were thrown to emphasize the strike call.

At 3 p.m., the local radio station broadcasted an official curfew order, to be effective from 8 p.m. that day until 5 a.m. the next day. Most of the hospital personnel do not have home telephones, but nearly all heard the news and came to the hospital before curfew time. The ambulance was sent to pick up a few key people for the evening and night shifts.

Meanwhile, an attempt was being made to secure curfew passes for the physicians and for key nursing and administrative personnel. Efforts were unsuccessful for two days, and when a physician was needed at night, the Lebanese army stationed near the hospital sent one of its men with the ambulance to pick up the doctor and return him home.

The same method was used for picking up patients, who were unable to reach the hospital otherwise. Passes were finally secured for slightly over 100 doctors, nurses, and administrative personnel, and for the ambulance.

For the rest of the employees, it was useless to obtain passes. Many of them live at some distance from the hospital, and no public transportation was available after about 7 p.m. For the first few days, personnel going off duty at 11 p.m. were forced to remain in the hospital, and those coming on duty found it necessary to arrive before the curfew hour.

After several days, when it appeared the curfew might remain in force for an extended period, schedules were changed, and a 12-hour night shift was effected for the nursing service. Instead of working an eight-hour, six-day week, personnel worked 12 hours a day for four days. Relief for days off became a problem, but the change was generally appreciated.

After about a month, the old curfew passes were revoked. Again short notice was given, and the procedure for obtaining new ones was more complicated. Each applicant was required to submit two photographs along with his address, his mother's name, and his father's name. Before all this could be accomplished, two days had passed during which

(Continued on next page)

*Administrator, American University Hospital, Beirut, Lebanon.

the ambulance was again operated without a pass. Fortunately, it was not stopped.

As reports of sporadic fighting reached the hospital, the next thought was to plan for the reception of casualties. The hospital was relatively full at the beginning of the crisis, and during the first week admissions were temporarily restricted to emergencies only. It was thought that a reserve of 20 beds below the average census could accommodate any likely number of casualties.

DROP IN ADMISSIONS

After a week it became unnecessary to restrict admissions, as the number of patients dropped because of transportation problems and the general uncertainty in the country. Hospital beds are strictly divided among clinical services, and it was established that casualties were to be admitted to the surgical ward, if any substantial number arrived within a short period of time.

No transfers of patients were made, since grouping of casualties could be done at the time of their reception by transferring or discharging patients in the designated area. Provision was made also for temporary expansion of bed capacity if it became necessary.

As the situation has developed, casualties have been occurring mostly in small numbers. Few incidents have injured large numbers of people, and in all cases they were nearer to other hospitals. The hospital does not normally receive many emergencies. These are generally directed to one of the hospitals having regular association with the local authorities. If people are injured in the vicinity, or if they are Americans or other non-Lebanese, they may be brought to our hospital. A number of casualties have requested to come.

Most of the casualties admitted have been in two categories: those who desire one of our attending physicians, and those for whom other hospitals in Beirut are not well equipped. Several in the latter group have had gunshot injuries of the head.

Casualties have been a relatively minor problem, except for one person who was under arrest during his stay in the hospital. Actually, the problem was with the guards assigned to the patient. One night they got into a political argument with another patient and were about ready to shoot him on the spot before physicians and nurses intervened.

One of the hospital's unusual services which was called upon is the emergency rescue service. This is a group of the resident staff, under the direction of an attending surgeon, organized to provide medical service and first-aid supplies wherever needed in Lebanon in case of any kind of disaster. It was organized at the time of the Suez crisis, and held several drills then.

On three occasions during the recent events the hospital received requests through the Red Cross to send this unit into the field. Only one of these calls developed into a real job for the team sent. That group went to a mountain area in which considerable fighting was taking place. In four days about 80 people reported for treatment. More than half of them had nothing to do with the fighting, but saw the opportuniy to receive free medical attention. They were referred back to their own physicians.

The arrival of American troops created considerable tension during the first few days of their presence. No one was quite certain how the various political factions in Lebanon would react, and we reviewed our preparations for handling casualties. It soon became obvious that the presence of troops was not going to provoke large-scale fighting and the hospital would not be called on to provide that kind of service.

We have been able to care for several cases for which the U. S. Army's field hospital is not equipped, including one of respiratory paralysis. Other services have included laboratory tests, water analyses, and embalming.

Services have been rendered also to three groups of United Nations personnel in the country: members of the U. N. truce supervision organization (concerned with the truce between Israel and the Arab states), the U. N. emergency force (set up after the conflict over Suez), and the U. N. observer group in Lebanon (established during the present crisis).

Members of these groups are regularly served by our hospital when they are in Lebanon. They present one peculiar problem—that of language. The hospital conducts its business of treating patients in English. Arabic is the most common conversational language, and French, Armenian, and Turkish are not unusual. The emergency force and observer group personnel come from many countries, and several have been able to speak only one of the Scandinavian languages. No translator for these languages has been found on the hospital staff—so everyone reverts to sign language.

TRANSPORTATION PROBLEM

Two of the three most critical problems have been created by the disruption of transportation. After the streetcar explosion, service was discontinued, and employees had to resort to more costly automobile and bus transport. At times even the usual routes taken by those forms of transportation were unsafe because of sporadic shooting, or were closed by the authorities. One employee walked more than 20 miles from his village to return to work after vacation because no cars were available.

The transport problem has also affected the food supply. Because the country is small, fresh fruits and vegetables are normally marketed as soon as they are harvested, and storage facilities are few. When goods do not arrive, there is no quantity to tide over until the next shipment.

A further complication is the hospital's lack of storage facilities, which are sufficient for only two or three days' supply of perishables. Our contractors for food products, with whom we have dealt for several years, have made special efforts to provide

the necessary items, and have been generally successful. Quality in some cases has not been up to standard, but certainly below-standard supplies are better than nothing.

The third critical problem has been that of the continuous tension. The uncertainty from day to day has taken its toll, and tempers have become shorter as the crisis has worn on without a solution. Only one serious incident occurred, in which an employee gravely insulted the wife of a high-ranking government official and had to be discharged. Political arguments between hospital employees on opposite sides of the fence have not been frequent, though it has been necessary to warn some of the more excitable staff members to pay more attention to their duties and less to the situation.

In general, the loyalty shown all over the world by people who care for the sick has been just as strong here. It is this loyalty, and the appreciation of the patients who come for treatment, that make the extra efforts required in such times worthwhile.

EFFECT OF POLITICAL EVENTS

Successive events in this part of the world have threatened for the last two years to disturb the normal operation of the hospital. The first of these was the conflict between Israel and Egypt over the Suez Canal. There were fears at this time that the conflict would spread and involve other nations, and disaster planning was begun then in earnest by the hospital.

The only effect of this crisis on the hospital was a temporary shortage of staple food items because of hoarding. This lasted only a few days, until the population was assured that supplies would continue to arrive.

The next event, in May, 1957, did disturb normal operations but was less significant in international terms. Just prior to the Lebanese elections for parliament, the prime minister was seriously ill and was admitted to the hospital.

The most serious problem was that of visitors. In this part of the world, when a person is sick, it is not only customary but almost obligatory for all his relatives and friends to visit him. This can create trouble in a hospital with relatively limited space for receiving guests. Normally, four visitors are allowed to a patient at one time. It is not uncommon to find 50 to 80 visitors on a nursing unit at visiting hours. Even more frequently, 10 or 15 persons want to visit one patient at the same time.

In the prime minister's case, visitors in the room and on the floor were few, since the physicians had ordered no visitors and the order was enforced by police stationed at the doors. During daytime hours, however, from 50 to 300 or 400 of his followers were sure to be present in the lobby and the garden.

At frequent intervals the president of Lebanon visited the hospital to talk to the doctors and the members of the prime minister's entourage. In proper observance of local hospitality, the hospital offered Turkish coffee to the group with the president in the conference room used for these gatherings.

The day of the prime minister's discharge was the climax of the two weeks. It had been planned the day before to discharge him on Sunday at 1 p.m. Early in the morning a number of people arrived and entered the garden in the center of the hospital compound before appeals to the police had any effect in halting the flow.

Shortly before noon, traffic had been brought to a halt around the hospital by parked cars full of people. Twelve camels were standing across from the hospital to lead the parade back to the prime minister's home. As he came out of the hospital (almost being crushed on the way by those who had been inside and now wanted to leave), a sheep was slaughtered on the sidewalk, and the procession of a thousand or so cars got under way with much blowing of horns.

Inside the hospital, all heaved a great sigh of relief.

The American University of Beirut was founded in 1866, and its medical school was started in 1867. The school of nursing and hospital opened in 1905. Presently the hospital has 225 adult and pediatric beds, and 25 bassinets.

The university and the hospital have gone through several periods of political unrest, in between which services to the Middle East have been steadily increased. More than 6,000 patients are admitted annually to the hospital, and the outpatient clinic receives more than 30,000 visits each year from persons who are unable to pay the full cost of their medical care.

Patients come from all parts of the world. About 60 percent are Lebanese and 15 percent are Syrian. The remainder come from Iraq, Saudi Arabia, Cyprus, Kuwait, Jordan, and some 40 other nations. Many of the Americans and Europeans living in these countries use the facilities of the hospital, since the standards of care are based on American medical and hospital practice. The hospital, in fact, is one of the few outside the United States and Canada which are fully accredited by the Joint Commission on Accreditation of Hospitals.

"SIL SPRAY"
LUBRICANT
For Instruments

Sil Spray puts a tough, thin, non gumming film on all metals. It remains stable at all temperatures. Stays on during sterilization.

SIL SPRAY IS SAFE!
Sil Spray is not oil. It is non-toxic and will not injure metal, rubber, paint or cloth. Special silicone formula requires no germicides or other additives.

ECONOMICAL!
One can goes a long way. Save time by spraying instruments by the tray full.

A "DUXE" PRODUCT
Your dealer has it, or, write—

DUXE PRODUCTS
205 Keith Building Cincinnati 2, Ohio

Alcoholism: Its Nature and Treatment

By the Rev. John J. Lazarsky, O.M.I.*

Part II. Professional Treatment

• Drinking is a serious problem not only to the excessive users of alcohol but also to the more than 25 million relatives, friends, business associates, and employers of these drinkers. Formerly, the alcoholic was considered a troublemaker; today he is viewed as a person who is more in trouble than one who gives trouble.

Once, those affected by his drinking were prone to remember the trouble he was causing them and to forget the turmoil in which he was stewing. But now, the tendency is growing for people to abandon the holier-than-thou attitude of repulsion toward the alcoholic; they are becoming genuinely sympathetic and intelligently helpful as they understand the nature of the problem and accept alcoholism as a complex and excruciating ailment.

It is imperative that understanding of the problem of alcoholism be extended to all, not confined to the specialists alone. This knowledge must be passed on to the doctors and the psychologists, the nurses and the social workers, the courts and the police, the teachers and the clergy, as well as to the nonprofessional persons with whom the alcoholic must live. Above all, the alcoholic must learn to understand himself and must find out just what means of rehabilitation are available to him.

Is there any hope of cure for the incurable? The alcoholic would resent this question if it were purely rhetorical, and rightly so; but in his case, it is a vital question. If by cure we mean that the alcoholic can again take or leave liquor at will, or that if he chooses to take it, he can leave it when there is danger of taking it immoderately—then he is beyond all cure.

Unlike the excessive drinker, who drinks heavily on occasion but who can stop when he chooses, the alcoholic has lost the power of choice; he can no longer control the time, the place, or the amount of his drinking. If he is to live a relatively normal life, he must live with this loss of the power of choice for the rest of his days. His sickness can be treated and arrested; but he cannot be cured or freed of it.

*Chaplain, Santa Rosa Hospital, San Antonio, Tex.

Although every alcoholic is incurable, no alcoholic is a hopeless case. There is some treatment or some combination of treatments for each one. Any alcoholic can learn to live with his sickness, just as a diabetic can do so with his illness. The alcoholic never can go back to moderate drinking, but he can learn to live a normal life without alcohol, and live it in such a way that he no longer has the need nor the desire for it, just as the diabetic can learn to exercise dietary caution and restraint. (However, I do not want to create the false impression that alcoholism and diabetes are alike in all or even most respects. As indicated in the previous article, there is a partial similarity in the physical aspects, and no more.)

The success of any treatment depends on the individual. Often, he can recover, but he must want to do so, and he must realize that he needs help. Before any treatment of the alcoholic can be successful, three essentials are required:

1. He must want to recover.
2. He must want to be treated.
3. He must be willing to continue the treatment.

As for the therapy of alcoholism. these factors are common to all methods of treatment:

1. It must demand and aim to achieve complete and permanent abstinence.

2. It must try to bolster the individual's determination to stay sober and help him to remain steadfast in his will to recover—the way back to a normal, happy, and productive life is not easy.

The American Medical Association, the American Hospital Association, and the World Health Organization have officially endorsed the concept that alcoholism is a sickness. However, there are still individual physicians, individual hospitals, and individual health officials and agencies who do not subscribe to this theory.

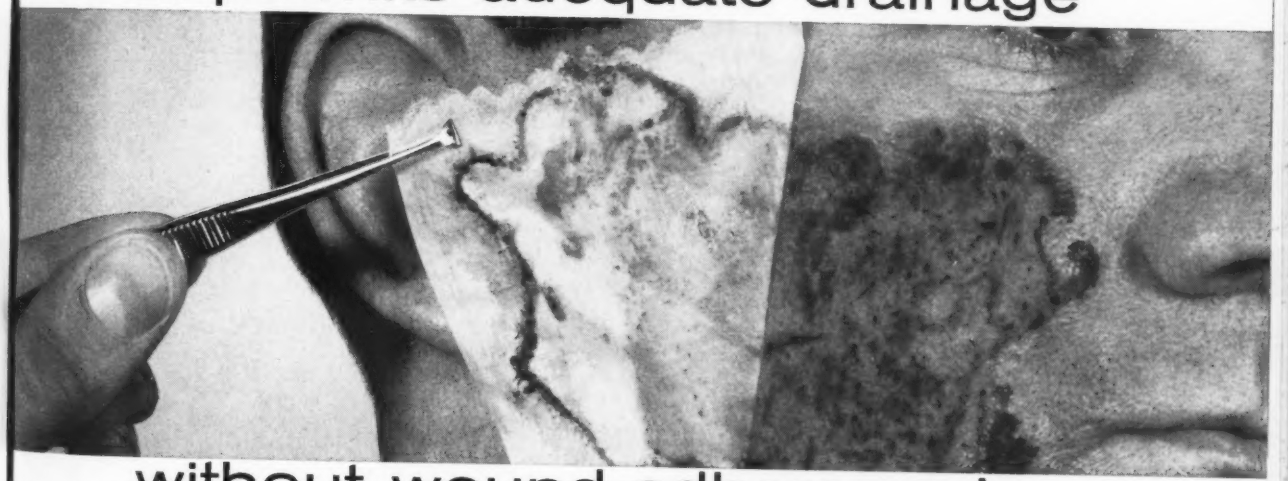
At one time, no condition was considered an ailment unless it was of a physical (somatic) nature. Then psychiatry proved that there are psychological

(Continued on page 42)

Tear Here
CYANAMID
STERILE
Owens®
Non-Adherent Surgical Dressing
INDIVIDUAL 3" x 8" DRESSING
PRODUCT 2343 PLAIN
Moisten with saline and apply as single layer.
Overlay with conventional gauze.
Applicable to burns, incisions, granulating areas, skin graft, donor and recipient sites, lacerations, abrasions and wherever a superior cosmetic result is desired.
AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
DANBURY, CONN., U.S.A.
Tear Here

New...a sterile contact dressing

that permits adequate drainage



...without wound-adherence!

The new sterile OWENS® Non-Adherent Surgical Dressing is "an ideal refinement in wound dressing technic."[1] This exclusive semi-permeable rayon fabric prevents capillary penetration without ointment or other impermeable coatings to hinder healing. Painful tearing of wound surfaces is minimized . . . better, more rapid healing is assured.

Double-wrapped dressings packaged sterile in individual envelopes ready for use on burns, incisions, granulating areas, skin graft sites, or wherever a superior cosmetic result is desired. Sizes: 3″ x 8″ and 8″ x 12″.

[1]Thomson, J. E. M.: Am. J. Surgery 91:413, 1956

CYANAMID

AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
NEW YORK, N. Y.

SALES OFFICE: DANBURY, CONN.

PRODUCERS OF DAVIS & GECK BRAND SUTURES AND VIM® BRAND HYPODERMIC SYRINGES AND NEEDLES. DISTRIBUTED IN CANADA BY: CYANAMID OF CANADA LIMITED, MONTREAL 16, P. Q.

(Continued from page 40)

(psychosomatic) ailments which are as real as physical diseases, although not as tangible via test tube and x-ray evidence. And now the world of medicine, going a step further, is beginning to realize that alcoholism, though a spiritual and moral condition from all appearances, is also physical and psychological in nature.

Some, of course, still find it difficult to accept alcoholism as an illness. Moreover, it is a complex ailment, which requires the services of the nonprofessional lay person as well as those of professional personnel in its treatment. The doctor is but one among many professional people who deal with the alcoholic: others include clergymen, sociologists, social workers, psychologists, legislators, and law-enforcement officers, and hospital personnel who become involved in the medical care of the alcoholic patient.

Although it is the proper function of the medical profession to declare what constitutes an illness and to define its nature, as well as to hospitalize patients, it sometimes happens that a doctor gives a vague diagnosis, bordering on the false, for a patient when the hospital does not accept alcoholics. Some hospitals resist acceptance because of their inflexibility concerning the flexible nature of the concept of disease.

HOSPITAL CARE

It is one thing when a hospital refuses certain kinds of patients because of a lack of proper facilities, and another thing when it declines them because of false notions and premises. Some medical hospitals refuse mental patients because they consider such patients "crazy" rather than sick; other hospitals which accept the mentally and emotionally sick will not allow alcoholics to occupy beds because, in the hospital's thinking, alcoholics are "tramps" or "weaklings."

The extent, quality, and grade of medical treatment offered to alcoholics in a given hospital depends largely upon the medical staff and its representation on the various hospital boards and committees. It is a common practice to house surgical patients apart from medical ones; in some hospitals, the mentally sick are separated from the other medical patients, also. In our day, it is the thinking of many doctors, especially psychiatrists, that mental patients, including alcoholics, should occupy the same floor or department as other medical patients, without distinction or discrimination, since this is a part of their therapy.

In most hospitals, the alcoholic can be treated for acute alcoholism, a severe hangover, delirium tremens, convulsions, and the so-called diseases of alcoholism. However, in many cases, neither the doctors nor the hospitals have the time or the facilities to give the full treatment. They seem to offer relief rather than a "cure," and must be considered the beginning not the end of the treatment; otherwise, the patient will only be discharged physically fit to start drinking once again. In specialized sanitaria for alcoholics, the patient undergoes a fully integrated treatment program which lasts for 60 to 90 days and sometimes even longer.

At the very outset of treatment, medical care should be offered the patient both as a human being and as an alcoholic. As a general rule, alcoholics are in very poor shape physically; they may even have some of the diseases of alcoholism. This is particularly true of the "Skid Row" type of patient who has had no one to care for him, who has been abandoned, and has abandoned himself, to the elements and a come-what-may fate, and who has consequently permitted himself to become physically depleted.

As any patient, the alcoholic should have a thorough physical examination, from head to toe, and should be treated accordingly. Particularly, he should be built up again. Some may even need hospitalization. An adequate supply of vitamins, a balanced diet, rest, cleanliness, good grooming, and medical care can help the aicoholic enjoy good health again and make him feel like a human being. What a wonderful feeling! And this feeling is necessary if he is to regain his human dignity. It is through his body that we must reach his mind and his soul.

From a physiological point of view alcohol must be classified as a food because it provides calories. In fact, alcoholic beverages generally have high caloric value: a jigger of whiskey has about 100 calories, a bottle of beer about 190, a 3-ounce glass of sweet wine about 150, and a glass of dry wine about 75.

However, the calories of this food, alcohol, differ from those of other foods inasmuch as these calories can be used only as fuel. They are burned to produce energy, and that is all; the body cannot use them to repair or build up tissues, nor can it store them for future use.

These facts show how continual, excessive use of alcohol in place of food will affect nutrition and cause bodily injury in the form of nutritional deficiency diseases. The calories from alcohol are the same as those from other foods, and when burned, do produce energy. But the body needs more than energy; it also needs vitamins, minerals, and proteins, and alcohol cannot provide these food values. Hence, alcohol is a very poor food, and a bad substitute for other foods.

MEDICAL CARE

The medical care offered to an alcoholic is somewhat specialized. If he is in the middle of a drinking episode, he may be able to conclude it at home, or he may have to be hospitalized. If he is actually drunk or has a hangover, treatment of the acute, toxic condition may be in order. In treating acute alcoholism and hangover, the withdrawal of the alcohol is accompanied by administration of various types of sedation which is gradually diminished and eliminated as soon as possible.

(Continued on page 44)

2 NEW STERILE AEROSOL PRODUCTS FOR BETTER PATIENT CARE:

first
trouble-free way
to stop
skin irritation

first
really effective
wound
deodorant

TOPASIL*

SILICONE SKIN PROTECTANT

One quick spray films skin with sterile, greaseless silicone coating . . . handiest, most effective safeguard yet for colostomy and ileostomy cases, prevention of bedsores, diaper rash and other troublesome skin irritations!

SURGAIRE*

DEODORANT SPRAY OINTMENT

Just spray sterile SURGAIRE on outside of dressing and cover lightly with gauze . . . checks **any** wound odor at source for more than 12 hours!

Place a trial order now for new SURGAIRE and TOPASIL—contact your Surgical Products Division Representative or order through your surgical supply dealer.

SURGAIRE and TOPASIL: each supplied in 3-oz. aerosol spray cans, 12 per carton.

*Trademark

PRODUCERS OF DAVIS & GECK BRAND SUTURES AND VIM® BRAND HYPODERMIC SYRINGES AND NEEDLES. DISTRIBUTED IN CANADA BY CYANAMID OF CANADA LIMITED, MONTREAL 16, P.Q.

CYANAMID

AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
NEW YORK, N. Y.

SALES OFFICE: DANBURY, CONN.

ALCOHOLISM

(Continued from page 42)

The process of "drying out" the alcoholic is just the first step in the long-range treatment of his drinking problem. In connection with the specialized medical care of an alcoholic, I would like to discuss endocrine therapy, conditioned reflex therapy, and the Antabuse treatment.

In some cases, endocrine, or glandular, therapy may prove that the basis of an individual's alcoholism is physiological, rather than psychological or spiritual. If the patient has a real wish to solve his drinking problem, he may submit himself to one or another of the various types of aversion treatments, which attempt to induce a conditioned reflex of disgust for alcohol.

Endocrine Therapy

Medical examination has revealed that an adrenal deficiency is responsible for the liquor habit in some persons. These persons are aware of two things: 1. They suffer from physical weakness, spells of mental depression, apathy, and assorted pains; 2. Alcohol gives them a temporary feeling of physical and mental well-being.

But they do not know, until they are told, that these symptoms follow an upset in the blood sugar balance, caused by a lack of sufficient adrenal hormones due to faulty functioning of the adrenal glands. Alcohol gives them a temporary lift because it sends the blood sugar soaring for a short period of time. When carefully measured doses of an extract of the adrenal cortex are given to patients who drink because of a lack of adrenal hormones, the initial disorder can be corrected.

Conditioned Reflex Therapy

The purpose of this treatment is to condition the alcoholic's reflexes in such a way that he will develop a strong aversion to alcohol and will become nauseated by the sight or smell or taste of it for some time. The treatment attempts to make him hate everything about alcohol, even the thought of it, so that automatically he will steer clear of it.

The treatment: The patient enters a sanitarium for a week or ten days. He is given four to eight hypodermic injection of emetine hydrochloride; with each injection he gets a drink of liquor. The drug causes nausea and vomiting, and the patient gets quite sick when treated to the emetine-liquor combination. The drug dosage is increased so that the nausea becomes more severe and lasts longer.

At the end of the treatment, a test: liquor without emetine. If the patient is nauseated by the mere smell of the liquor and vomits immediately after tasting it, he passes the test and may go home.

Result: The patient has no trouble staying on the wagon for some time.

Antabuse Treatment

A potent drug, Antabuse sets up a sensitivity to alcohol; it will make the patient violently ill if alcohol is taken while the drug is in the system. Antabuse tablets are taken daily as long as the treatment lasts.

Unlike emetine, Antabuse, taken by itself, does not cause nausea or vomiting. But if even a small amount of alcohol—less than one ounce—is ingested after an Antabuse tablet—watch out! Flushing of the face, severe headache, nausea, congestion of the eyes, heart palpitations, a rise in the pulse rate, and other unpleasant symptoms may follow. If the patient takes a "stiff" drink after Antabuse, hospitalization is required. The alcoholic is afraid to drink as long as he keeps on taking Antabuse, for he knows from personal experience what the result would be.

The aversion treatments have definite limitations. While they abolish the craving for alcohol by setting up an aversion to it, thus making it easy for the individual to abstain, they do not make drinking impossible. Although in some cases they suffice to arrest the patient's drinking by themselves, for best results they should be used in conjunction with psychotherapy. The chief value of such treatment is that it affords periods of enforced sobriety during which the alcoholic may be benefitted by psychotherapy and other aids, and may readjust his way of life under more favorable circumstances.

Alcoholism as a sickness of the mind is over and above any neurotic or psychotic condition the alcoholic may have; however, such a condition may be at the root of his trouble and may drive him to drink. The addiction or compulsive thinking regarding liquor, which takes possession of the alcoholic in such a way that he just cannot think of anything else at the moment, is posterior to these other psychic illnesses.

The psychiatric treatment offered to the alcoholic should concern itself with both of these aspects of his mental sickness. It will lessen and check the second, that is, the alcoholic addiction or compulsion, if it uncovers, attacks, and progressively reduces the first, the underlying conflicts and tensions which cause him to drink excessively.

The distinction between a compulsive drinker and an alcoholic should be kept in mind. The former is one who, although he wishes to stop drinking, is irresistibly driven to it by an unconquerable fear that he cannot live without liquor. The latter, the alcoholic, is one who, in consequence of prolonged, excessive drinking, has developed a pathological craving for alcohol.

Not necessarily, but most frequently, a person becomes an alcoholic through compulsive drinking; not necessarily, however, because there are other causes. Some become alcoholics because of an adrenal deficiency, others as a result of relying on alcohol over a period of years to relieve the discomfort or pain of some physical disease or disorder which they have doctored themselves. Still others become alcoholics in an effort to adjust themselves to the so-called "change of life" and to relieve certain

(Continued on page 49)

Nursing Services in the Hospital

I. Organization of the Nursing Service

By John H. Gorby*

• Nursing service has the heavy responsibility of translating the products and technics of medical and physical sciences available in today's hospitals into actual recovery of the individual patient. It is the means through which the resources of the hospital are focused on the patient. Yet, in this capacity, the nursing service depends greatly on other hospital units for its over-all effectiveness.

SPECIFIC RESPONSIBILITIES

In considering the role of nursing and its contribution to the patient's welfare, it is useful to define the specific responsibilities of the nursing service. These are three-fold—responsibility to the patient, to the medical staff, and to the hospital administration.

Formally stated, the nursing service is responsible for the care of the patient, under the direction of the doctor and pursuant to the rules of the hospital. Yet this definition is neither a rigid nor a universally applicable one. In any institution, no matter how small, spheres of authority overlap.

The amount of nursing care patients are receiving in a particular institution may be computed in the following way: Total the number of registered nurses, and the number of aides giving bedside care, on duty during any 24-hour period. Multiply this figure by eight, then divide by the average daily census. The result is the average number of hours of nursing care per patient per day.

ALLOCATION OF NURSES

Each of the hospital's three services—medical, surgical, and obstetrical—requires a minimum number of registered nurses.

The medical service requires, as a minimum, a supervisor and a medicine nurse, both registered in the state in which the hospital is in operation. Additional nursing personnel need not be registered. Very effective medical nursing care has been given by practical nurses, undergraduates, and similar personnel.

The surgical service requires a surgical supervisor and two registered nurses. The work in the operating room is of such importance that no attempt should ever be made to function with fewer than these three registered nurses. However, additional help in cleaning up and performing other operating-room tasks may, if necessary, be provided by technicians, nurses' aides, or maids.

The obstetrical service requires an obstetrical supervisor plus a nursery nurse, both R.N.'s. The nursery may be handled very adequately by nurses' aides or undergraduates. It is not necessary for the nursery to be under the direct supervision of a registered nurse, provided the obstetrical supervisor, herself, is an R.N.

EFFECTIVE UTILIZATION

Standardized operational procedures and practices will be of considerable help in utilizing nursing personnel most effectively. Inevitably, there will be times when one unit has too many graduate nurses and another does not have enough. Ideally, the hospital could simply reassign the nurses to compensate. Instead, however, a hospital may find that it takes several days to orient a nurse to take over duties in a different unit from the one in which she has been working because of a lack of standardized operations.

Variations in procedure affect not only graduate nurses, of course, but other personnel as well. Often the same task is performed by a professional nurse in one unit and by a nonprofessional employee in another. In a third unit, the job may even be done by someone from the housekeeping or the dietary department.

Obviously, when a professional nurse does a task in one unit, that unit's ratio of nursing hours per day per patient goes up in comparison to a second unit in which the same task is done by a housekeeping or dietary employee. Similarly, in the latter unit, it would require more nurses to provide the same amount of nursing care.

The head nurse can determine standards in assigning tasks by making a study to discover exactly who performs each of the essential, subprofessional duties in the unit. One such study showed that 138 of 157 subprofessional duties, or 88 percent, were being per-

(Continued on next page)

*1816 Lincoln Ave., San Diego 3, Calif.

formed by professional employees on one or more of the nursing units.

Among the duties frequently performed by nursing personnel in one unit, and by housekeeping or dietary personnel in other units are changing bed mattresses, changing cubicle curtains, cleaning bathrooms, cleaning refrigerators, and disposing of flowers.

Nurses also lose much time moving to and from departments outside their immediate nursing units. They travel back and forth from central sterile supply, the pharmacy, the x-ray department, the operating room, the laboratory. Making a study of a typical 72-hour period, including information such as time each person leaves, when she returns, cause of leaving, and similar factors, will usually be most revealing and will help emphasize any existing need for better organization.

For example, if the study shows that excessive time is being spent getting supplies from the pharmacy, it should be obvious that floor stocks are insufficient and that the list of items kept on hand and amounts of each should be re-examined.

Added to the time loss resulting from unnecessary trips must be the loss resulting from the interruption which the departure itself causes—the amount of time needed to resume work at the pre-interruption level of efficiency.

From this discussion, it is evident that many of the tasks often performed by professional nurses could be done by undergraduates and practical nurses. Under the direction of the nurse in charge, undergraduates may perform almost every type of bedside care except the administration of medications. This may be done only by the medicine nurse—the registered nurse charged with this responsibility—whatever the title she is known by in a particular hospital.

Practical nurses and nurses' aides may be used to supplement bedside care. Typical duties they may handle include answering lights, carrying trays, assisting in feeding patients, giving baths, and changing linens.

ORDERLY POOL

Nursing personnel may also be relieved of doing other types of nonprofessional work by means of a central orderly pool. Personnel in such a pool are responsible for moving patients and running errands to areas of the hospital outside of the immediate nursing unit.

From 2.4 to 4 man hours per nursing unit are spent in moving patients and running errands, according to studies. Average time per trip can be reduced by use of an orderly pool. At the same time, better planning can be provided for the use of personnel in such trips. The pool can be part of a nonsterile supply unit, which can be responsible for control, storage, and maintenance of nonsterile nursing equipment, checking such equipment, and even making repairs between trips.

Thus, a nursing unit which needed nonsterile items such as air mattresses, heat cradles, oxygen equipment, or suction apparatus, could have the items delivered immediately from the locale of the pool.

On our floor
R35
R36
R43
R41
R48
R49
R201A
THESE ARE JUST A FEW OF THE PLEXITRON® SOLUTION AND BLOOD SETS WE USE. THE BROCHURE YOU HAVE EXPLAINS EACH ONE IN DETAIL. FRANKLY, YOU'LL GET SO YOU TAKE THEIR TROUBLE-FREE PERFORMANCE FOR GRANTED.
BAXTER LABORATORIES, INC.
Morton Grove, Illinois

Efficient and economical operation of the nursing service can only be achieved by intelligent allocation of responsibilities to skilled professional nurses on the one hand, and on the other, delegation of less demanding duties to practical nurses, nurses' aides, and other less highly trained personnel.

CENTRAL STERILE SUPPLY

One department in which such an apportionment of responsibilities can be arranged with good effect is central sterile supply. The department should, of course, be under the general supervision of the director of nurses. However, a person who has sufficient training in, and knowledge of, the sterilization of the various materials and equipment used in the hospital, the preparation of packs, and the other details involved in central supply operation, may be in charge or may assist in the functioning of this department. Learning to manage a central supply department is not excessively difficult. But the job demands good common sense and a familiarity with the requirements of sterile technic.

EFFICIENCY OF OPERATION

If there is one unforgivable sin in the assignment of nurses, it is the use of trained nursing personnel for performing nonnursing duties such as admitting, and keeping medical records. Since the demand for trained professional nurses is so often greater than the supply, their work should be confined scrupulously to the field in which they are most skilled and best qualified.

Registered nurses should never be given nonnursing duties which, in many cases, could be done by others. There will always be many more applicants for these nonnursing jobs than there will ever be nurses. One of the most tragic evidences of inefficient operation observable in some hospitals is the sight of a trained, registered nurse engaged in a purely clerical operation which requires no specialized, professional knowledge.

Care of the Patient

For example, the nursing service is responsible for the bedside care of the patient. However, the housekeeping department is responsible for keeping the room clean, for seeing that linen supplies, pillows and blankets are readily available, and similar tasks. If regular liaison is not established between the nursing service and the housekeeping department, there might be a conflict of authority in this area.

Responsibility to the Medical Staff

The nursing service is responsible to the medical staff for carrying out explicitly the orders given by the attending physician for the care of his patient. The doctor's orders must be written—a requirement which leaves little to the discretion of the nurse. Unless it seems to the nurse in charge that a doctor's orders are grossly out of place, the orders must be carried out as written and at the time specified.

The only exception to this rule, judging from legal precedent, is in cases in which a nurse finds herself ordered to give what she considers, within the purview of her own knowledge, a fatal dose of medicine.

Should a nurse find herself in this situation, it is her responsibility to call the attending physician and

(Continued on next page)

LET'S SEE NOW. . . 4-WAY SAFETY HEAT SEALS . . . FLO-TROL CLAMP . . . SQUEEZE-FILL DRIP CHAMBER . . . FLASHBALL TO MAKE SURE NEEDLE IS IN VEIN AND TO ADD MEDICATION . . .
AND DON'T FORGET THE BLOOD FILTER . . . FINE-MESH WITH GREATER FILTERING AREA.
WRITE FOR YOUR COPY OF THIS 32-PAGE, SET-BY-SET DESCRIPTION OF THE PLEXITRON® LINE
PLEXITRON® expendable sets
pioneering parenterals for a quarter century

confirm the ordered dosage. If the doctor insists his written orders are correct, the nurse is required to chart immediately the fact that she has notified the doctor of the circumstances and make a record of his telephoned instructions. Such chart entries are the only protection she and the hospital will have in the event of subsequent inquiries.

Responsibility to the Hospital

The third portion of nursing service's responsibilities is to the hospital, itself, to carry out the general orders of the institution as issued by the board of trustees through the administrator. These orders should always be in a written form which is always available. They should cover such details as procedure for admission of patients, specification of routine laboratory examinations, requirements for surgical procedures, and similar policies. There should be no deviation from these standard orders.

MINIMUM KEY PERSONNEL

If these three categories of responsibility are to be met effectively, every hospital, no matter how small, requires a certain minimum of key nursing personnel, each of whom has specific responsibilities. They are:

—A superintendent or director of nurses.

—A nurse in charge of each shift.

—A surgical supervisor.

—An obstetrical supervisor.

Superintendent or Director

The superintendent or director of nurses is responsible to the administrator for the dispensing of nursing service to the patient and for seeing that the orders of the attending physicians are carried out.

Table 1: Nursing Service Standards—National League for Nursing*

Service	Average Number of General Nursing Hours Per Patient	Percent of General Nursing Hours Given	
		Professional Personnel	Other Personnel
Ward and semi-private accommodations			
Medical	3.4	65	35
Surgical	3.5	70	30
Mixed (medical and surgical)	3.4	67	33
Obstetric			
Postpartum mothers	4.0	65	35
Newborn infants	2.8	77	23
Pediatric, all ages	4.6	80	20
Private accommodations			
Medical and surgical	3.8	76	24

*A study of Nursing Service in One Children's and Twenty-One General Hospitals. New York: National League for Nursing Education, 1948.

Shift Supervisors

Each shift supervisor is responsible for the nurses on duty during her shift. It is the duty of these supervisors to see that the orders of the hospital, of the director of nurses, and of the attending physicians are promptly and carefully followed.

Surgical Supervisor

The surgical supervisor sees to it that operations are scheduled only by doctors who have surgical privileges at the hospital. She makes sure that the operating room is prepared, that instruments necessary for the procedure are available, and that everything possible is done for the care of the patient during the time he is in the operating room, subject, of course, to the over-all authority of the surgeon during that time.

Obstetrical Supervisor

The obstetrical supervisor is responsible for the care of maternity patients while they are in the labor room and in the delivery room and during the postpartum period. She is also responsible for the nursery, particularly for insuring that every precaution is taken there subject to the rules of the hospital.

HOSPITAL NURSING REQUIREMENTS

In determining the amount of nursing service a hospital requires, the standard recommended by the National League for Nursing is useful. This group suggests that any well-organized general, acute hospital with a medical, a surgical, and an obstetrical service should probably have a minimum of three and three-quarter hours of nursing care per patient per day. This amount may be less in specialized institutions, such as those for the care of tubercular or geriatric patients exclusively, but would probably be a little more in a specialized maternity hospital.

The League standards are detailed in Table 1, which shows the average number of general nursing hours needed per patient in every 24-hour period, and also the percentage of total nursing hours which should be

Table 2: Average Number of Nursing Hours per Patient Day in 18 Hospitals (1956)

Service	Average Number of General Nursing Hours Per Patient	Percent of General Nursing Hours Given	
		Professional Personnel	Other Personnel
Ward and semi-private accommodations			
Medical	3.2	51	49
Surgical	3.6	46	54
Mixed (medical and surgical)	3.4	51	49
Obstetric			
Postpartum mothers	2.7	60	40
Newborn infants	3.0	70	30
Pediatric	4.1	55	45
Private accommodations	3.3	57	49

Table 3: Table of Organization, Medical Nursing Units

	30-Bed Unit	40-Bed Unit
Professional		
Head nurse	1	1
Day shift	3	3
Afternoon shift	2	2
Night shift	1	1
Nonprofessional (female)		
Day shift	2	3
Afternoon shift	1	1
Night shift	1	1
Nonprofessional (male)		
Day shift	1	1
Afternoon shift	½	1
Night shift	1	1

on a professional level and the percentage which may be on a less than professional level.

As an additional basis of comparison, it may be useful to refer to the result of detailed studies made in 1956 of a group of 18 hospitals. These hospitals were considered to have achieved a peak quality of nursing. By averaging the figures from all of these hospitals, the standard shown in Table 2 was developed.

Of course, this standard represents an average. Generally speaking, the principal factor which varied from hospital to hospital was the size of the nursing unit. The example in Table 3 shows the difference in the organization developed between a 30-bed and a 40-bed medical unit.

TRAINING FACILITIES

A final word should be said about the hospital which does not have a nursing school. Such hospitals are apt to find their nurse recruitment problems much more serious than those of hospitals which have nursing schools. The solution is simple and obvious. A hospital without a nursing school should plan, as soon as feasible, to begin recruiting girls to be trained as nurses.

This article is the first in a 5-part series concerning various types of nursing service in the hospital. Future articles will discuss "The Role of the Practical Nurse," "A Good Obstetrical Service," "Efficient Organization in the Operation Room," and "Central Supply—the Nerve Center of the Community Hospital."

ALCOHOLISM

(Continued from page 44)

distressing symptoms due to the glandular changes in that period of life.

Psychiatric treatment must first determine whether or not the alcoholic is actually a compulsive drinker. Then it must proceed to teach him to understand himself and his problem, to accept himself as he is and to live with himself as such, and to accept the fact that recovery is possible only if he refrains completely from drinking.

The psychiatrist will not lecture the patient about drinking; usually he has had the questionable benefit of this dubious type of therapy from his family for several years before he decided to come for medical treatment. Nor will the psychiatrist simply admonish the alcoholic not to drink. Rather he will pinpoint and clarify the patient's problem and offer suggestions for possible courses of action. But he will leave the decisions to the patient.

The psychiatrist will try to help the alcoholic acquire a new understanding of himself and his behavior by permitting him to speak freely about everything and anything that may have a bearing on his drinking and by asking all kinds of leading and searching questions. Mindful that no one longs for unconsciousness, partial or complete, or seeks to drug himself, unless he is in pain, the psychiatrist will endeavor to find the specific emotional problem or physical condition from which the alcoholic suffers and for which he resorts to liquor for its narcotic effect. The physician knows that the degree of his patient's addiction indicates to what degree his state of tension, fear, anxiety, and indecision, in turn, has become chronic, and, in turn, how mild or deep-seated his inner conflicts have become.

Since alcoholic addiction is basically a psychological or mental illness, it is essential that the alcoholic understand the real, underlying motive or drive behind his drinking. People drink for a variety of reasons, but many of them, especially compulsive drinkers, do not know why they drink. Normal drinkers use alcohol for reasons which are usually neither complex nor mysterious, but pathological drinkers frequently have deeply hidden reasons of which they may not be aware.

Group therapy can be used to great advantage as an integral part of psychiatric treatment. Five to eight problem drinkers get together to talk out their problems, under the supervision of a psychiatrist or psychologist. The members give and receive moral support from each other and feel at ease in discussing their problems since they all have similar troubles.

The purpose of all psychiatric treatment is to assist the pathological drinker in overcoming his compulsive thinking in regard to alcohol and the neurotic or psychotic condition which causes his mind to be obsessed by alcoholic addiction and drives him to drink excessively.

The treatment will be successful: 1. If the alcoholic has definitely stopped drinking—an indication that his thinking is being corrected; 2. If he has really begun to face up to his problems—which means that he is taking care of the inner conflicts that drove him to drink; and 3. If he no longer feels the need of turning to liquor in order to escape his troubles—proof that he no longer thinks of alcohol as indispensable, and no longer labors under the fear that he cannot live without it.

Next month: Nonprofessional treatment of alcoholism.

Left: Two student nurses sample salmon loaf at the "tasting table" in the employee cafeteria, University of Kansas Medical Center. They will record their approval or disapproval on cards which will be tabulated. If the food is well accepted, it will appear on the regular menu.

Tasting Table Helps Dietitians Add Variety to Staff Menus

By Helen M. Sims* and Elizabeth McCune†

• "Getting them to try" has been a rewarding experiment for the department of dietetics and nutrition, University of Kansas Medical Center, Kansas City. The 200 members of the department are constantly attempting to please both patients and personnel. The department's latest effort to improve employee menus, a "tasting table," enlisted the help of the personnel themselves.

A few months ago, a linen-covered table, appropriately decorated, made its appearance in the employee cafeteria. It was unveiled during a lunch hour, without fanfare or publicity. Attended by a supervisor from the department, the table was strategically located so that patrons had to walk by it on their way to the cafeteria line. And walk by they did—until the attendant pointed out its attraction, a new and unfamiliar dish, which she urged them to sample.

Staff dietitians were convinced that new foods and recipes could become popular additions to the menu if the customers would only try them. Further, the staff wanted employees' opinions on the proposed additions.

The attendant on the first tasting table worked hard to put over the new idea, and her enthusiasm paid off. Nurses, physicians, and other personnel stopped, dubiously tasted the sample, then recorded their reactions on a card which contained these questions: "Do you like it?" "Does it look good?" "What would you like to have it served with?"

Such was the beginning of the tasting table at this 600-bed hospital. It has been so well-received that the problem now is one of expediently serving the table's eager patrons. The table still makes its appearance, unannounced, on different days of the week, although not every week. During its "one hour show," people wait in line to taste and to approve or disapprove. The table is always decorated in keeping with the dish or dishes offered.

Results of each test are tabulated, and the dietitians act accordingly, following the majority rule. If an offering is well-accepted, it appears on the regular menu.

The tasting table is only one of the department's efforts to improve food service. Since patients, too, are "customers," the 18 dietitians and 10 dietetic interns at the Medical Center also conduct periodic patient surveys. The most recent one involved a questionnaire given to every hospital patient to determine likes and dislikes of both food categories and specific dishes. Patients were asked if they wanted certain foods "often," "seldom," or "never." Their answers were statistically analyzed and used as a guide in writing a five-week cycle menu.

Drastic changes resulted—the selective menu now offers a smaller variety of foods but with more repetition of popular dishes. The staff has found that people who are ill may be reluctant to try foods with which they are not familiar.

Approximately 50 percent of the hospital's patient census is drawn from the rural areas of Kansas. Thus, the dietetic staff feels that these patient surveys truly indicate rural Midwest eating habits. The staff has learned, for instance, that roast beef and spaghetti and meat balls are popular enough to be served three times a week. Potatoes are desired at both the noon and the evening meals.

It has been found that patients are better-satisfied and more co-operative when they have an opportunity to participate in the choice of food for their menus. And it is just this principle, applied to the hospital employees, which has made the tasting table a valuable and successful experiment.

*Director of Informational Services, University of Kansas Medical Center, Kansas City.

†Assistant director, department of dietetics and nutrition, University of Kansas Medical Center.

Health Insurance *Newsletter*

By Sen. George R. Metcalf

EDITOR'S NOTE: With this issue, HOSPITAL TOPICS inaugurates a department devoted to brief items reporting on recent developments in the field of health insurance. The author is a member of the New York State Senate and has been chairman of its joint legislative committee on health insurance plans since the committee was created in 1955.

• The State of New York Joint Legislative Committee on Health Insurance Plans was established in 1955, "to ascertain ways and means of *extending adequate coverage* through voluntary health, accident, hospital and surgical insurance to the greatest number of people in the state . . ."

An additional objective specified for the committee has already been achieved: "To establish criteria for various health insurance plans affecting State and retired State employees." Employees of New York State now participate in one of the most comprehensive and most progressive health insurance plans in the country.

There are essentially three parts of the plan—standard Blue Cross hospitalization, plus Blue Shield, Health Insurance Plan, or Group Health Insurance, plus major medical coverage. The major medical coverage is offered only in combination with Blue Shield on the theory that it is not really necessary when an employee is covered by HIP or GHI.

A unique feature of the plan is that many retired employees may also retain their coverage after at least five years of service.

* * *

Mental Illness. Evidence is mounting of increased concern over the fact that most Blue Cross and commercial health-insurance coverage does not include mental illness. On July 18, Julius S. Wikler, New York state superintendent of insurance, was reported by the *New York Times* to have called on all Blue Cross plans in the state to include hospitalization for mental illness in their basic contracts.

Mr. Wikler urged them, according to the *Times*, to follow the lead of the Rochester Blue Cross plan, which since May 1 has provided 30 days of hospitalization for mental care, narcotic addiction, or alcoholism.

On August 5, the *Times* reported on a letter to Mayor Robert Wagner from Anthony B. Akers, chairman of A Community Team for Mental Health, urging the Mayor to call a city-wide conference to discuss mental health coverage in insurance contracts, specifically Blue Cross contracts.

The problem of prepaid care of mental illness will be examined by the New York State Joint Legislative Committee on Health Insurance Plans at a public hearing scheduled on Thursday, November 13, in Buffalo.

* * *

"Fundamental Disagreement." Commercial companies generally oppose legislation aimed at preventing them from canceling health insurance policies because of excessive claims or the advanced age of the insured. The philosophy behind such legislation and the opposition to it were spelled out in many pages of testimony at hearings conducted over the past three years by the New York State Legislative Committee on Health Insurance Plans.

The very crux of the issue developed, however, in a brief exchange which took place in Albany, February 27, 1957, between myself, as committee chairman, and Gerald S. Parker appearing on behalf of the Health Insurance Association of America, the American Life Convention, and the Life Insurance Association of America.

Following is a transcript from one part of the record of that hearing:

THE CHAIRMAN: We have had testimony here today by the Blue Shield of New York City in which they said they collect the same premium throughout the life of an individual. They don't cancel on account of age. Therefore they have, in effect, what amounts to a level premium throughout life. Now, they haven't gone broke. In fact, I think we had figures here today which showed they had more than four million subscribers . . . I would like to know why commercial plans can't do the same thing.

(*Continued on next page*)

George R. Metcalf was elected to the New York State Senate in 1950 and has served continuously. This is not his first experience as a columnist. His column appears in his home-town paper, the Citizen-Advertiser, *Auburn, N.Y.*

MR. PARKER: Well, there are several reasons. I can't speak for the actuaries of the Blue Shield, and they may want to defend themselves, but I think that they are, in the first place, primarily in the group business and that their individual contracts are a relatively small portion of their exposure. I think, also, that they are able, if they have a loss on the individual policy, to charge it up to the groups. We can't do that.

THE CHAIRMAN: Why?

MR. PARKER: Because I believe it is illegal and I know it is inequitable.

THE CHAIRMAN: Why is it inequitable?

MR. PARKER: It is inequitable because the people in the groups are paying a price based on group administration . . . They contract to buy coverage for themselves. It would be just as unfair to ask them to pay for the cost of health insurance on the natives of Africa.

THE CHAIRMAN: I don't think we would go that far, but I think we are, to an extent, our brother's keeper, and I think that is a denial of the fact when you have certain groups which have no responsibility for other groups.

MR. PARKER: Well, sir, there I think we just come to a fundamental disagreement . . .

* * *

Anniversary. Joseph Frayman, reporting to the *New York Times* from London on the 10th anniversary of the inauguration of Britain's National Health Service, observed: "It has become an accepted part of British society. Few of the physicians who originally opposed socialized medicine would abolish it now."

* * *

Recommended Reading: "Voluntary Health Insurance and the Senior Citizen—a Report on the Problem of Continuation of Medical Care Benefits for the Aged in New York State." Otherwise known as the Downey Report, this was submitted to Gov. Averell Harriman on February 26, 1958, by F. Roger Downey, then administrative assistant in the State of New York insurance department.

SAVE OPERATING ROOM TIME
HELP THE SURGEON

Use *Steri-Spools in a Halliday Wire Cutting Dispenser

You get the size and length of sterile wire you want as you want it.

NO SNARLS — NO KINKS
NO WASTE

If your dealer cannot supply, write to the manufacturer—

THOMAS W. HALLIDAY
911 N. WESTMOUNT DRIVE
LOS ANGELES 46, CALIF.

*Trade Mark Registered

The report consists of 215 pages of thoughtful, painstaking analysis of all the factors involved in the problem of establishing a level premium structure for medical care insurance policies guaranteed renewable for life. Exhaustively researched and abundantly documented, with actuarial tables and formulae, it is destined to constitute a landmark in this field.

Highlight of the report is a series of seven legislative recommendations for:

—Encouragement of insurers and employers to continue benefits for employees on retirement.

—Issuance of group health insurance benefits to "associations of persons having a common interest or calling"—e.g., farmers, professionals, tradesmen.

—More generous conversion privileges for employees covered by group policies so that they can continue to be covered when they retire.

—Mandatory notification to employees concerning their conversion privileges.

—Liberalization of insurance law provisions relating to eligibility for coverage by reason of age.

—Guaranteed renewability of individual policies at a level premium.

—Protection of aged policyholders against denial of health insurance benefits on the ground of preexisting conditions.

Copies of the report, priced at $1.25 each, can be obtained from Leo Doyle, New York State Insurance Department, 324 State St., Albany, N.Y.

* * *

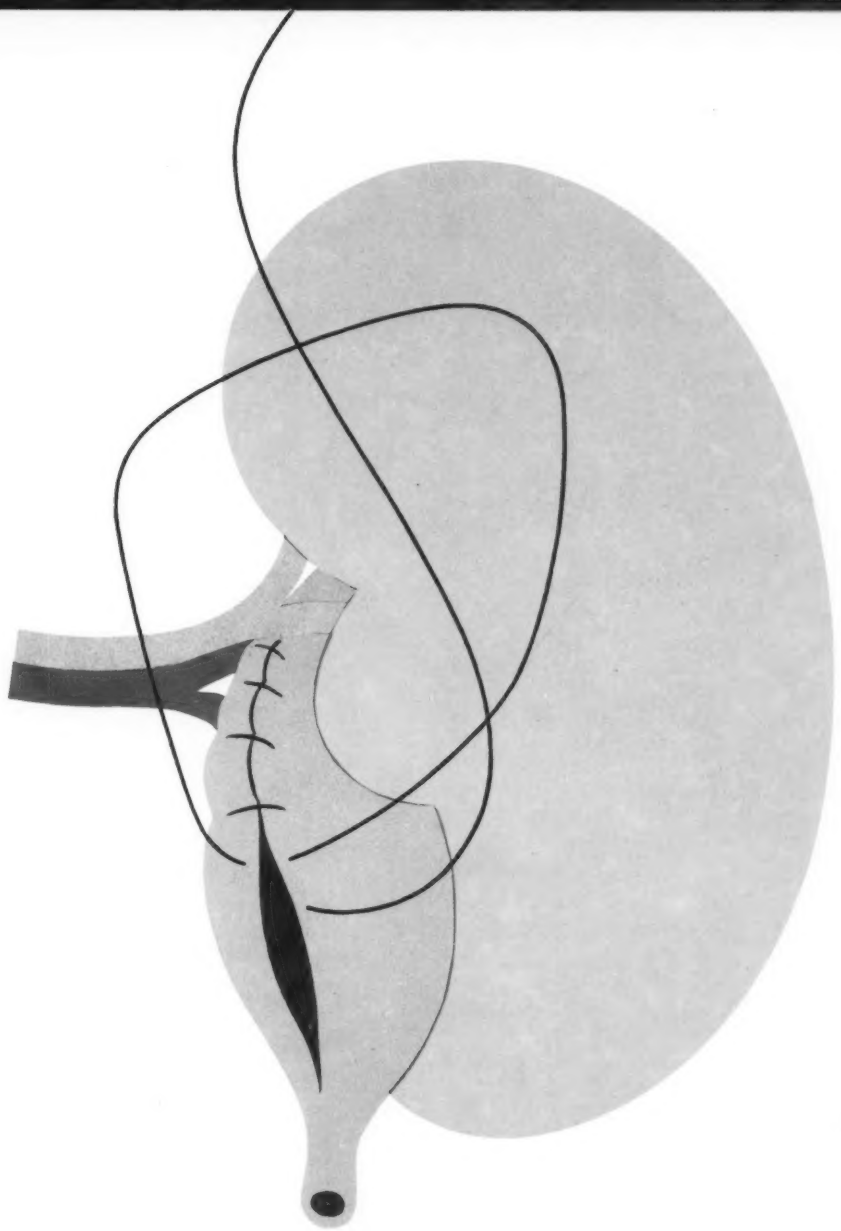
"Due Process" and Blue Cross. Three hospitals have initiated legal action to nullify portions of a ruling on Blue Cross rates handed down April 15 by Francis R. Smith, insurance commissioner of Pennsylvania.

Commissioner Smith's ruling indicated he would not approve requests for future Blue Cross rate increases unless satisfied the plan making the request had undertaken certain steps. These steps involve specific cost-cutting procedures and other economies designed to eliminate alleged abuses such as over-use of hospital facilities.

In their appeal, Bryn Mawr, Lankenau, and Germantown hospitals are reported to raise constitutional questions. They maintain that Commissioner Smith's directives, if sustained, would deprive hospitals, without due process of law, of properties "given to them in trust by countless thousands of charitable donors."

The insurance commissioner's directives, the complaint charges, constitute an unlawful interference with the "proper performance of the duties of the directors and trustees" of the hospitals "as set forth in their respective charters and bylaws."

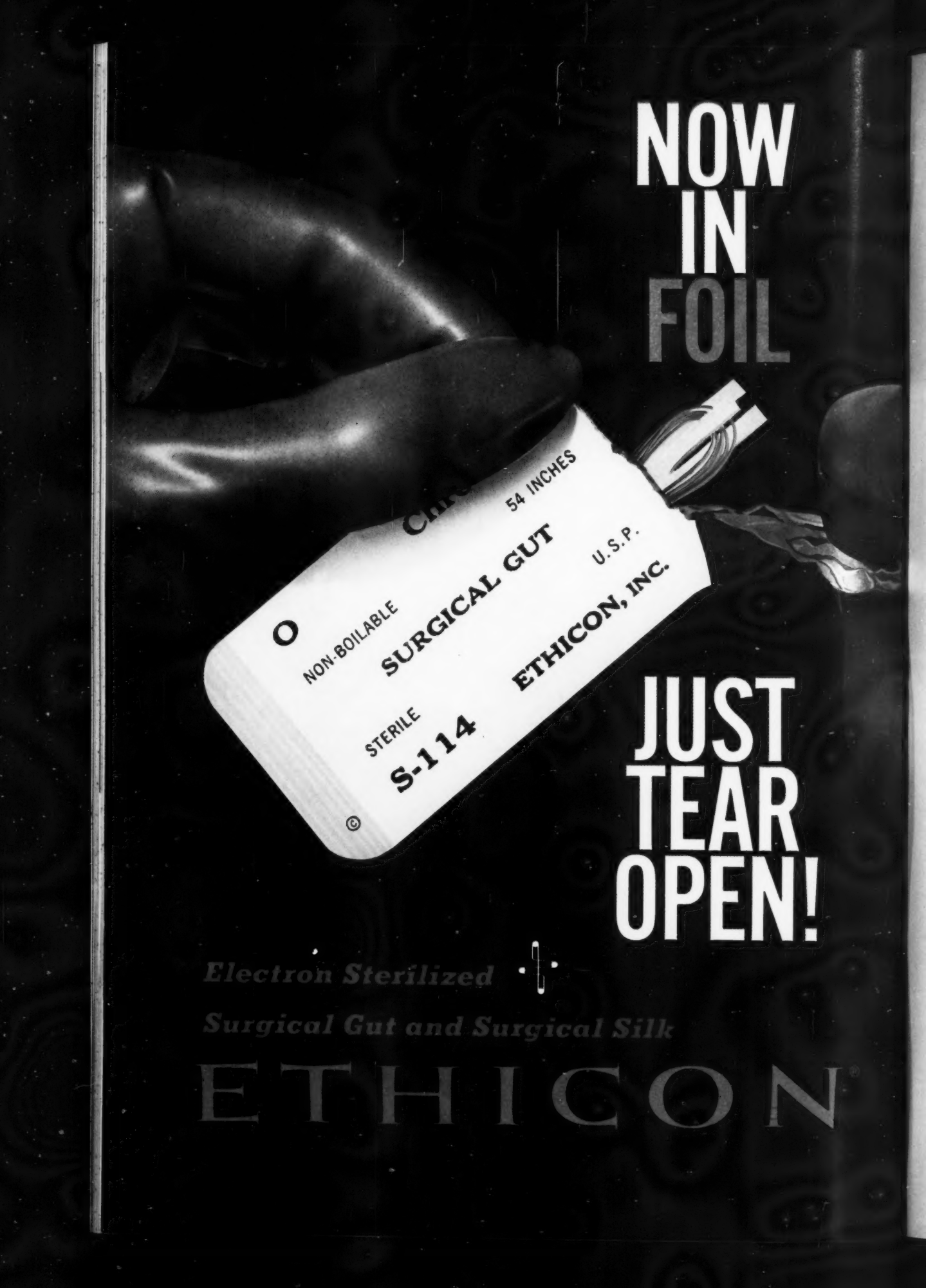
The question the court will have to resolve, apparently, is the extent to which an administrative office of a state government is empowered to encroach upon the policy-making prerogatives of the directors of voluntary, nonprofit hospitals. These prerogatives have by law and tradition been exclusively exercised by the hospitals themselves.



setting new standards

ETHICON®

sutures


NOW IN FOIL
54 INCHES
O
NON-BOILABLE
SURGICAL GUT
U.S.P.
STERILE
S-114
ETHICON, INC.
©
JUST TEAR OPEN!
Electron Sterilized
Surgical Gut and Surgical Silk
ETHICON

Regional Differences in U. S. Hospitals

By Louis Block, Dr. P.H.

*Payroll Expenses**

Eleventh in a series

The largest amount of payroll expense in:

1. All hospitals was in the Middle Atlantic region.

2. Short-term general hospitals was in the Middle Atlantic region.

3. Nonprofit short-term general hospitals was in the East North Central region.

4. Proprietary short-term general hospitals was in the West South Central region.

5. Governmental (excluding federal) short term general hospitals was in the Middle Atlantic region.

6. Long-term general hospitals was in the Middle Atlantic region.

7. Psychiatric hospitals was in the Middle Atlantic region.

8. Tuberculosis hospitals was in the Middle Atlantic region.

9. Federal hospitals was in the South Atlantic region.

More than half of the total payroll expense in all regions is in short-term general hospitals. In this group, nonprofit controlled hospitals account for the largest share.

In the West South Central region, the proportionate share of total payroll expense in proprietary and governmental (excluding federal) short-term general hospitals is greater than in other regions. Proportionately, the East South Central, South Atlantic, West South Central, and Mountain regions have a larger share of their payroll expense in federal hospitals than do the other regions.

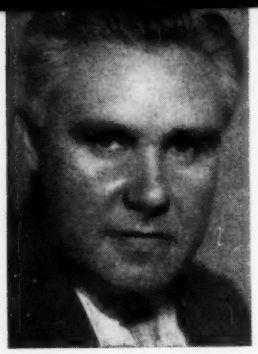
1. The Region as a Part of the United States

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific	Total
Total	8.2	24.1	11.0	21.1	4.5	8.6	6.7	3.6	12.2	100.0
Short-Term General	8.0	23.6	9.9	23.3	4.0	9.3	6.6	3.3	12.0	100.0
Nonprofit Short-Term General	9.4	25.0	8.4	25.6	3.4	9.7	4.9	3.3	10.3	100.0
Proprietary Short-Term General	1.3	15.2	18.6	5.0	8.9	7.1	25.0	1.5	17.4	100.0
Gov'tal (Excl. Federal) Short-Term General	4.9	20.6	12.8	19.8	4.9	8.5	8.6	3.6	16.3	100.0
Long-Term General	10.2	36.7	7.2	23.2	1.7	4.3	2.2	1.6	12.9	100.0
Psychiatric	11.3	33.9	8.2	20.3	2.2	7.1	3.9	2.6	10.5	100.0
Tuberculosis	8.4	22.9	12.5	26.0	4.4	6.8	3.9	3.0	12.1	100.0
Federal	5.8	15.7	17.5	13.2	8.5	12.6	10.5	6.0	10.2	100.0

2. The Region as an Entity in Itself

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
Short-Term General	57.9	57.9	52.8	65.4	52.5	64.0	58.7	53.8	58.1
Nonprofit Short-Term General	49.2	44.5	32.5	51.8	32.4	48.2	31.4	38.9	36.1
Proprietary Short-Term General	0.4	1.6	4.3	0.6	5.0	2.1	9.5	1.1	3.6
Gov'tal (Excl. Federal) Short-Term General	8.3	11.8	16.0	13.0	15.1	13.7	17.8	13.8	18.4
Long-Term General	4.4	5.4	2.3	3.9	1.3	1.8	1.2	1.6	3.8
Psychiatric	20.7	21.1	11.1	14.4	7.3	12.8	8.8	10.6	12.8
Tuberculosis	3.8	3.5	4.2	4.6	3.6	3.0	2.2	3.1	3.7
Federal	13.2	12.1	29.6	11.7	35.3	18.4	29.1	30.9	21.6
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Based on the 1956 Administrators' Guide Issue, *Hospitals*, Journal of the American Hospital Association.



By John G. Steinle

Consultant's Corner

Q. How long should medical records be kept?

A. This is probably one of the most controversial questions in the hospital field. Before attempting to solve this problem, the administration should answer the following questions about the hospital:

1. What is the role of the hospital? A teaching and research institution must keep records longer than a hospital which functions to provide care for the community.

2. What is the system for keeping records? A hospital which brings its records up, assigning a new number or otherwise identifying the active records, can more easily dispose of inactive records.

Keeping these two factors in mind, the record committee should form a well-defined policy for records disposal. This policy should be reviewed and approved by the hospital's attorney. The following is a suggested guide for disposal.

Teaching hospitals should hold:

—All records, including those of operative procedures, for 20 years;

—All records of minors until the patient reaches at least 21 years of age;

—All records with interesting medical diagnoses for at least 20 years;

—Records of interesting teaching cases indefinitely.

Nonteaching hospitals should hold:

—All records of minors until the patient is 21 years of age;

—Records with interesting diagnoses and all records of surgical procedures for 15 years;

—All other records for 10 years.

Q. How much space should be provided for filing medical records?

A. This of course depends on the size of the individual records and the retention policy. A fair average is to figure from seven to 10 records per inch of filing space. The ratio of filing space to square inches of floor space, including aisles for clerks to work in, for the three major types of equipment, are these:

1. The shelf-type cabinet, permanently closed on three sides—3.63 square inches of floor space for each inch of filing space.

2. The side-opening file cabinet which contains a series of shelves suspended so that in opening a compartment of the file, the access to the shelf turns in a 90 degree angle on a small radius and, when opened, projects only 7½ inches from the body of the cabinet —5.63 square inches of floor space for each inch of filing space.

3. The conventional 5-drawer cabinet—6.2 square inches of floor space for each inch of filing space.

Q. What are the requirements for medical record librarian training?

A. Two organizations are primarily concerned with the training of medical record librarians. These are the Council on Medical Education and Hospitals of the American Medical Association and the American Association of Medical Record Librarians. The council establishes standards, inspects and approves schools, and publishes lists of accepted schools. The association is concerned with the promotion of educational activities and the registration of qualified librarians.

There are 29 approved schools for medical record librarians in the United States. The admission requirement of schools with 2-year programs is two years of college or an R.N. The admission requirement for the 4-year programs usually is a high school diploma.

Hospitals and persons interested in further information should contact the American Association of Medical Record Librarians, 510 N. Dearborn St., Chicago 10, Ill.

Q. Do you recommend microfilming records in community hospitals? If so, after how long?

A. We have made a number of studies of the use of microfilm records. Usually, use of the records is greatly reduced after they have been microfilmed. For example, in one hospital the records which were opened 10 years previously were called for 810 times during the year. Subsequently, the hospital embarked on a microfilming program. Afterward, 10-year-old records were requested only 92 times during the year. Thus, there is always the danger of important data in microfilmed records being ignored because of the reluctance of the medical staff to use the films.

Microfilm mounted on cards is the only system recommended. This system permits easy filing, handling, and use.

Generally, it is safe to microfilm all records after they are five years old.

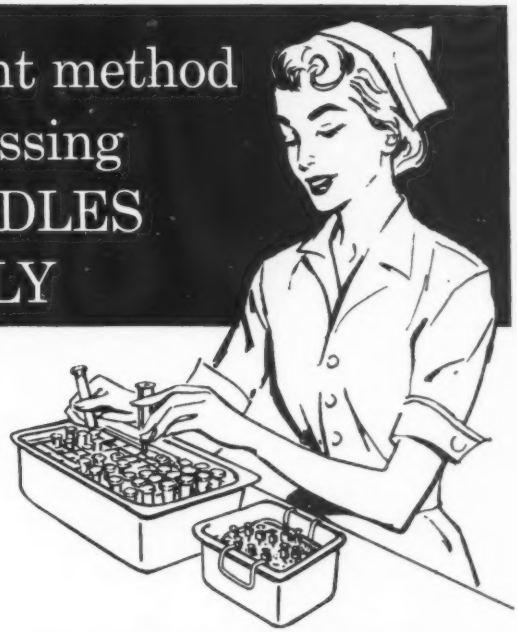
Q. Do you recommend microfilming records in teaching hospitals?

A. It is difficult to use microfilm in teaching hospitals because in most, records are reviewed in a number of different places. Hence, equipment for reproduction must be located in a number of areas, making maintenance and control of equipment expensive.

Q. What is the cost of microfilming?

A. The minimum cost of microfilming is approximately ½ cent a sheet. Preparing the record for microfilming costs approximately 6 cents a record. The average record contains 22 sheets; the cost of microfilming an average record thus would be approximately 17 cents.

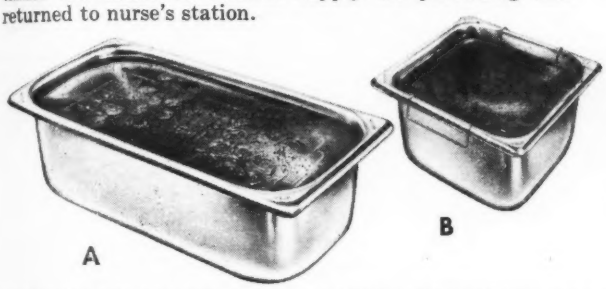
NEW!—a more efficient method of handling and processing SYRINGES and NEEDLES for CENTRAL SUPPLY



After use, syringes are disassembled. Plungers and barrels are placed in separate compartments in Syringe Rack (A). The rack rests in a stainless steel soak basin containing a solution of Weck Cleaner.

Needles are inserted in cellulose sponge (B) of the Soiled Needle Container. An important feature is that this sponge *will not float* because the rack is clamped to the stainless steel soak basin, which contains a solution of Weck Cleaner.

When filled, both Syringe Rack and Soiled Needle Container are taken to Central Supply for processing and returned to nurse's station.



ADVANTAGES OF THIS METHOD

Insertion into sponge protects needles from damage.

Pre-soaking prevents foreign material from solidifying or clogging needles, thus simplifying cleaning.

Minimizes hand contact—protects personnel from infection or skin irritation.

Reduction of handling practically eliminates breakage of syringes.

Simplifies counting and checking of returned syringes.

WECK SOILED INSTRUMENT RACK

—a simpler, safer method of processing soiled instruments

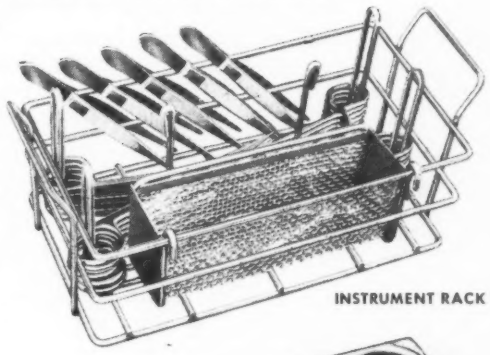
All hospital authorities agree that the present methods of handling instrument packs on floors leave much room for improvement.

Consider the following advantages of the new procedure using the Weck Instrument Rack:

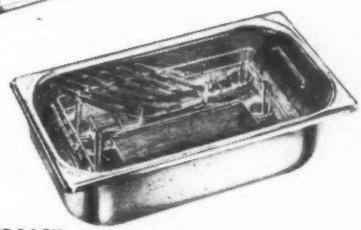
- after use, the instruments are immediately placed in the rack which is immersed in the Weck Soak Basin containing a solution of Weck Cleaner.
- with scissors and forceps, finger rings are slid over separated, upright prongs. The result—blades, jaws, etc. are open, giving ready access to the solution.
- thumb forceps may be straddled over the sides of the rack.
- a separate removable compartment holds smaller instruments—probes, clip removal forceps, etc.
- this pre-soaking eliminates arduous scouring of caked blood, pus, etc.
- all instruments remain in the solution until returned to Central Supply Room.
- contaminated instruments cannot be mistaken for clean ones.
- instruments in the rack permit quick, easy tally by C.S.R. personnel.
- after return to C.S.R. Soiled Instrument Rack is lifted out and pre-sterilized before proceeding with washing, sorting, etc.

For complete information on the revolutionary Weck method of handling and processing syringes, needles, catheters, instruments, etc. for Central Supply, write for Specialty Folder No. 7 to:

EDWARD WECK & COMPANY • DIVISION OF STERLING PRECISION CORP.
135 JOHNSON STREET, BROOKLYN 1, NEW YORK



INSTRUMENT RACK



INSTRUMENT RACK
IMMERSED IN SOAK BASIN

WECK

68 YEARS OF KNOWING HOW

Manufacturers of Fine Surgical Instruments and Hospital Specialties • Instrument Repairing

For additional information on products advertised, circle number on reply card opposite page 152. 57

Review of Hospital Law Suits

By Leo Parker,
Attorney at Law

• Mechanism Caused Injury

• Recently, an official of a hospital corporation wrote an interesting letter as follows: "For many years I have followed your writing with interest and considerable profit by learning how to prepare to avoid law suits. An important law you seem to have overlooked and have not previously explained relates to injuries to employees caused by devices and mechanisms. What is the law? When is the manufacturer of a mechanism liable for injuries to our employees while operating the mechanism?"

A short time ago a higher court answered these questions, in Standard Conveyor Company v. Scott, 221 Fed. (2d) 460. The testimony showed these facts: The Conveyor Company installed a conveyor in a building. An employee sustained serious injuries to his hand while operating the conveyor for which he sued the manufacturer for heavy damages. During the trial the employee's legal counsel charged that the manufacturer negligently designed, manufactured, and installed the conveyor. The jury returned a verdict in favor of the employee for $25,000.

The manufacturer appealed to the higher court contending that the recognized rule of law is that a manufacturer is not liable to third persons or employees for negligence in the construction, manufacture, or sale of articles unless the article sold is inherently or "imminently dangerous."

The higher court agreed with this contention and reversed the jury's decision, saying:

"It is perfectly obvious that there was nothing latent, hidden or defective about the condition and that the distance between the conveyors was open and obvious for all to see. We do not believe it can be said that the condition was inherently or imminently dangerous any more than any moving machinery may be said to be inherently or imminently dangerous. To hold the manufacturer and installer of this equipment liable for injuries would be tantamount to holding the manufacturer and installer of any moving machinery responsible for all injuries connected with its use."

This higher court went on to explain that the term "imminently dangerous" does not always mean that the article or mechanism must "at all times" be imminently dangerous. It suffices if the nature and quality of the thing sold is reasonably certain at some time during its operation to place life or limb in peril, and was negligently made.

For comparison, see McLeod v. Linde Products Company. 1 S. W. (2d) 122. In this case the testimony showed that a hospital corporation purchased oxygen in steel tanks with an outlet valve at the top of each tank. The tanks remained the property of the manufacturer and were returned to it when empty. Fifteen minutes after the delivery of a tank, an employee of the corporation undertook to use the tank. The oxygen did not flow and the tank seemed to be empty. It appeared, however, that the valve had become clogged by rust and other substances. Upon being subjected to a pressure of 1,800 pounds per square inch, the valve suddenly cleared and the gas escaped in an explosive manner, whereby the employee was seriously injured.

This court held the manufacturer and seller of the tank liable for injuries to the employee and explained that since the dangerous condition of the tank was not known to the employee or his employer the tank, because of its defective condition, was "imminently dangerous."

REASONS FOR HIGH DAMAGES

An official of a hospital corporation asked this question: "What is the reason the present day courts allow higher damages to patients, guests, and employees than were awarded a few years ago?"

The answer is: The dollar is worth less.

For example, in Trow v. Abbot, 190 Fed. (2d) 825, the testimony showed that Trow was 44 years of age when he was seriously injured. He was permanently disabled and was hospitalized for 14 months, suffering extreme pain. The jury originally awarded $150,000 damages to Trow but the damage allowance was reduced finally to $126,182, by the higher court, which said.

"A careful study of the evidence of damages in the record has failed to convince us that this verdict was so grossly excessive as to justify reversal on this ground."

The higher court went on to explain that the value of the dollar at this time is considerably decreased, when compared with what could be purchased with it only a few years ago.

In view of these established facts, officials of hospitals should exercise great care to abide by compensation laws under the State Workmen's Compensation Act, and also to carry adequate insurance

(Continued on page 60)

AMAZING NEW DISCOVERY

TIME AUTOCLAVE LABELS

WITH

TSI

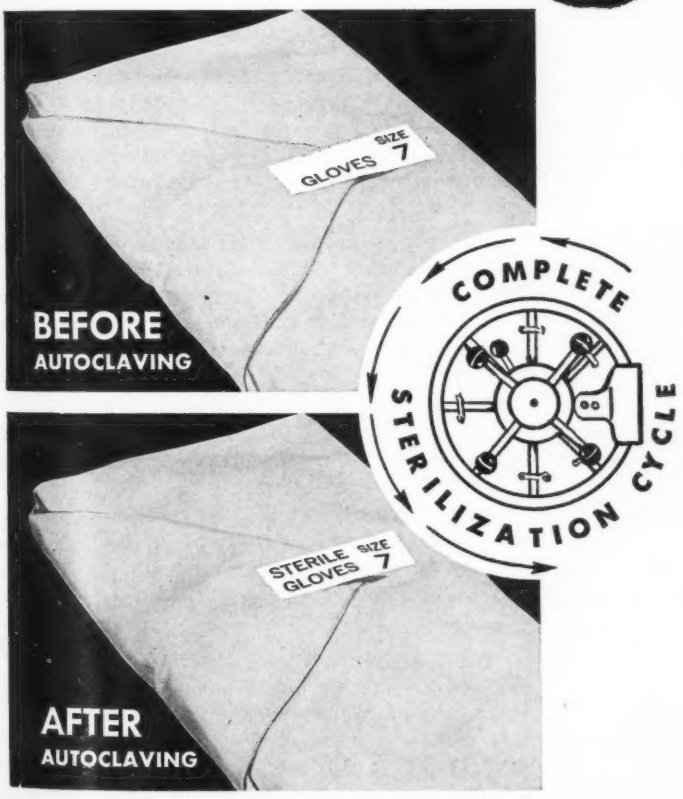
(TIME STERILE INDICATOR)

TSI . . . is a scientific development designed to take the guesswork out of autoclaving. TIME AUTOCLAVE LABELS with TSI (Time Sterile Indicator) are actually a time indicator. They give visual proof that the item has been subjected to the complete autoclave sterilization cycle. The word "sterile" appears in bold black letters only after exposure to autoclaving temperatures of 250° F for at least 15 minutes. Accidental activation is impossible.

Only TIME AUTOCLAVE LABELS with TSI (Time Sterile Indicator) give you these outstanding time and convenience features. In a single operation they seal . . . identify . . . show size and number of articles . . . give visual indication of sterilization . . . and eliminate pencil mark mistakes.

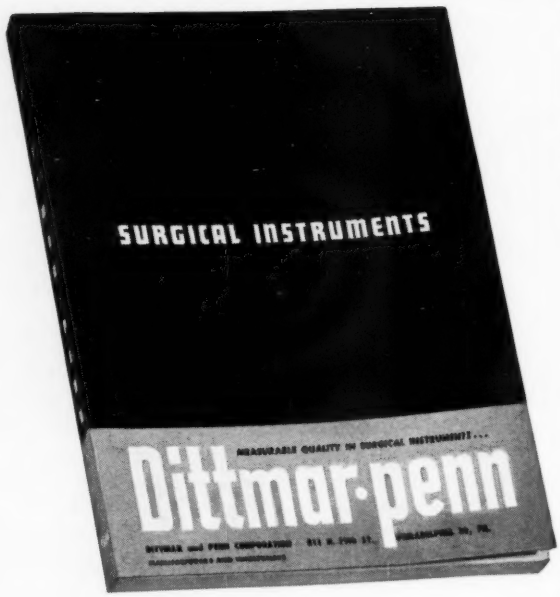
For the most modern hospital and laboratory labeling procedures . . . use TIME AUTOCLAVE LABELS with TSI (Time Sterile Indicator). A large selection of standard labels available.

Write for samples and catalog today!



TIME SELF-STICKING LABELS VINYL COATED

PROFESSIONAL TAPE CO., INC. • 355 BURLINGTON ROAD
Riverside, Ill. • Dept. 41-B • Riverside 7-7800



NEW: Beautifully designed, fully illustrated, 250-page complete catalog of Dittmar-Penn Instruments—arranged for convenient reference. Ask for your copy.

Famous for quality, variety, reliability and service for nearly 60 years

The complete, modern line of Dittmar-Penn stainless steel surgical instruments and hospital specialties is the reflection of many years of manufacturing experience in serving the requirements and preferences of surgeons, operating room supervisors and hospital management.

That is why Dittmar-Penn practically always has the design you want—eliminating bothersome "shopping".

This quality line, offering the maximum of dependability and long life, is competitively priced.

When you buy Dittmar-Penn, quality is an economy, not an expense.

Ask your hospital and surgical supply dealer to show you the popular instrument set displays or write for descriptive literature.

MEASURABLE QUALITY IN SURGICAL INSTRUMENTS...
Dittmar·penn
DITTMAR and PENN CORPORATION . 811 N. 19th ST., PHILADELPHIA 30, PA.
MANUFACTURERS AND WHOLESALERS

LAWSUITS

(Continued from page 58)

against injuries of patients and guests while on hospital premises. In one recent case, for example, a hospital corporation carried a $25,000 indemnity insurance policy. A guest was injured and the higher court awarded him $38,000 damages. The insurance company paid $25,000 and the hospital corporation was ordered by the court to pay the deficiency, amounting to $13,000.

MUST PROVE EMPLOYEE'S NEGLIGENCE

Recently, a higher court rendered a decision which answers a legal question often presented to the writer in the past by hospital officials and employees. This question is substantially as follows: "If a visitor to a hospital is injured due to apparent negligence of an employee of the hospital corporation, is the latter always liable in damages to the injured person?" For instance, one official said: "We now have a suit against us filed by a visitor who was injured by our employee who was assisting him up steps leading into our hospital."

A higher court rendered an important decision to the effect that a hospital corporation never is liable in damages for injuries to a patient or visitor who is being assisted or served by an employee unless the thing which caused the injury was within control of the hospital officials and, also, the injury resulted from negligence of the hospital corporation's employee.

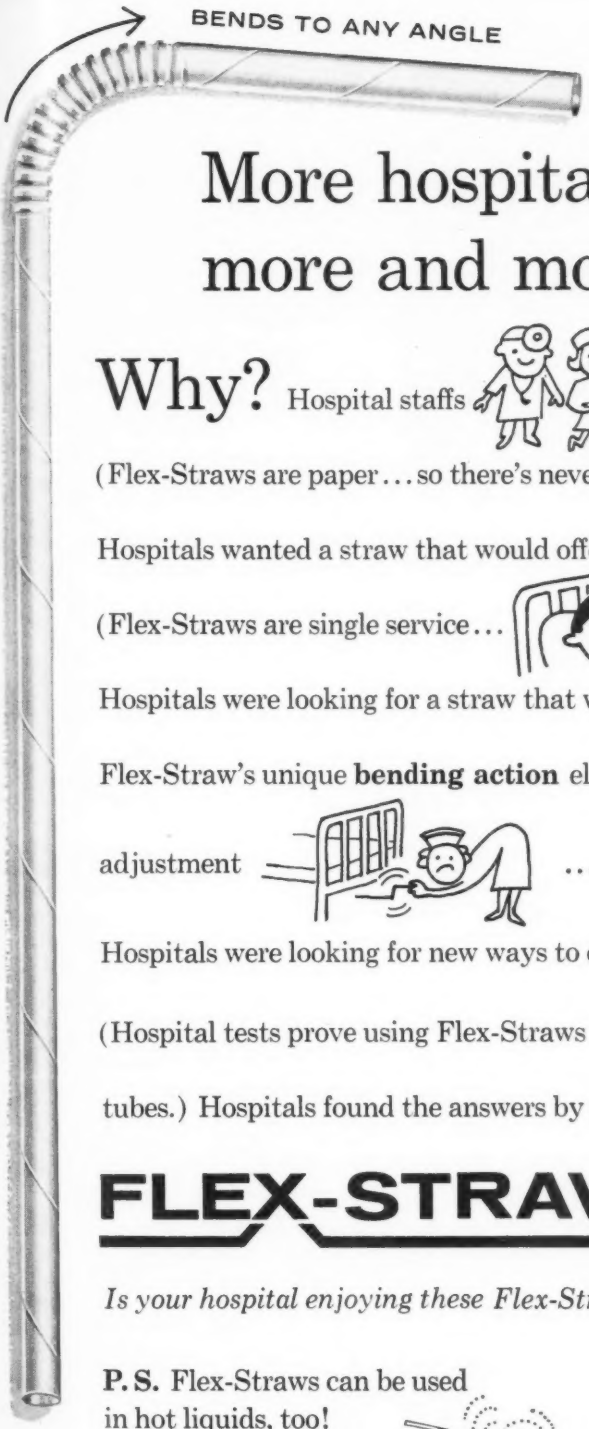
See Schor v. McDaniel, 291 S. W. (2d) 6, where the higher court refused to hold that an injured visitor named Schor could recover damages from a corporation whose employee was assisting the visitor to ride in a wheel chair when the injury was sustained.

For many years Schor had suffered from an arthritic condition which required her to use a wheel chair to get about. The particular chair she was using was portable and collapsible; when opened, it had a mechanism underneath which, when fastened, held the chair erect.

One day an employee of the hospital corporation was requested to take the chair and assist Schor to get into it. The employee placed the chair near the entrance on the sidewalk. The chair collapsed after the employee had pushed her about three feet. From this accident she suffered severe injuries. Later she died.

The higher court held the corporation not liable in damages, and said:

> **"We find that neither inspection nor use of the wheel chair at the time of Schor's injury was in the control of appellee (corporation). For this reason, and because of the fact that the ownership, control and right of inspection of the chair were vested in appellant (son) and his mother, they were in a much more superior position than was appellee (corporation) to explain the cause of the casualty."**



More hospitals are using more and more Flex-Straws!

Why? Hospital staffs wanted a straw that was **safe**

(Flex-Straws are paper... so there's never any danger of broken glass.)

Hospitals wanted a straw that would offer their patients added **cleanliness**

(Flex-Straws are single service... they're always fresh as a daisy.)

Hospitals were looking for a straw that was **convenient** and **efficient.**

Flex-Straw's unique **bending action** eliminates lost motion in patient bed adjustment ...and Flex-Straws are **disposable** too.

Hospitals were looking for new ways to **economize**

(Hospital tests prove using Flex-Straws is more economical than using breakable tubes.) Hospitals found the answers by using...

FLEX-STRAWS®

Is your hospital enjoying these Flex-Straw advantages?

P. S. Flex-Straws can be used in hot liquids, too!

refer to
HOSPITAL PURCHASING FILE
for listings and prices

CANADIAN DISTRIBUTOR: INGRAM & BELL LTD.
TORONTO, MONTREAL, WINNEPEG,
CALGARY, VANCOUVER

FLEX-STRAW Co. Int'l.
2040 Broadway · Santa Monica, California

FLEX-STRAW CO. INT'L. HT
2040 Broadway
Santa Monica, Calif.

Please send samples and literature

NAME_____
HOSPITAL_____
ADDRESS_____
CITY_____ STATE_____

Personally Speaking

Officers of the Vermont Hospital Association shown at the group's annual meeting, held October 8-9 in Burlington, are (left to right): Alex I. Nemeth, assistant administrator, Rutland Hospital, secretary; Ralph H. Ross, administrator, Brightlook Hospital, St. Johnsbury, president-elect; Frederick A. Hale, controller, Mary Fletcher Hospital, Burlington, treasurer; Lester E. Richwagen, administrator, Mary Fletcher Hospital, retiring president; Ralph R. Betts, administrator, Kerbs Memorial Hospital, St. Albans, president. Also elected at the meeting were new trustees: Rocca Mittica, administrator, Rockingham Hospital, Bellows Falls; Joel Walker, administrator, Barre City Hospital; and Leslie Morse, Gifford Memorial Hospital, Randolph. Bronze and marble plaques were presented to Mother Collins, former administrator, DeGoesbriand Hospital, Burlington, and Thomas S. Brown, administrator, Mary Fletcher Hospital, for outstanding service to hospitals and health care.

Mrs. Hazel Adams—has been appointed food supervisor, Nassau General Hospital, Fernandina Beach, Fla. **Mrs. Alice Bodine** is the new office manager.

Carden M. Astin—is now administrator, Blount Memorial Hospital, Oneonta, Ala.

Perry Balzer—has been appointed comptroller, American Oncologic Hospital, Philadelphia.

Mildred Bateman, M.D.—has been appointed superintendent, Lakin (W.Va.) State Hospital. Dr. Bateman had been acting superintendent at the hospital since the resignation of **S. O. Johnson, M.D.** Dr. Johnson recently completed her psychiatric residency at the C. F. Menninger Memorial Hospital, Topeka, Kans.

Luke Birky—has been named administrator, Mennonite Hospital, La Junta, Colo. He was formerly administrator, Pioneers Memorial Hospital, Rocky Ford, Colo.

Grace Higginbotham Burgess, R.N.—has resigned as director of nurses, Jefferson Memorial Hospital, Crystal City, Mo.

L. Ben Clarke—previously business manager, Macon (Ga.) Hospital, has been appointed administrative assistant, City-County Hospital, LaGrange, Ga.

Also appointed to the administrative staff of City-County Hospital was **Edgar W. Smith,** who last year completed the hospital administration course at Georgia State College of Business Administration, Atlanta.

Audrey Clepper, R.N.—has been appointed director of nurses, Fort Walton Beach (Fla.) Hospital.

Mrs. Rosalie S. Collins—has been named head of the newly combined dietary and housekeeping departments, Belle Glade (Fla.) Memorial Hospital.

Robert G. Curran and **Richard G. Warner**—have been named assistant administrators, Boston City Hospital. Mr. Curran was formerly assistant administrator, Johns Hopkins Hospital, Baltimore. Mr. Warner was previously administrative assistant and assistant managing director, New Britain (Conn.) General Hospital.

Mary E. Donahue, R.N., and **Edmund J. McTernan**—have been named administrative assistants, Malden Hospital, Boston. Miss Donahue was previously educational director of the hospital's school of nursing. Mr. McTernan formerly was administrative resident, Muhlenberg Hospital, Plainfield, N.J.

Mary Emerson, R.N.—has become supervisor, auxiliary personnel, Hartford (Conn.) Hospital. She was previously director of nursing service, St. Francis Hospital, Hartford. **Sister Gabriella** succeeds her in this position.

Also at St. Francis Hospital, **Mary Davey, R.N.,** has assumed the position of assistant director of nursing service. **Sister Suzanne,** who was formerly assistant director of nursing service, has been appointed supervisor of the intense care unit now being planned. **Mrs. Kathryn Brummitt, R.N.,** is assistant supervisor of nurse aides.

Frieda E. Enss—has been appointed assistant administrator, St. Louis (Mo.) Children's Hospital.

Franklin C. Fetter, M.D.—has been appointed director, medical education, Presbyterian Hospital in Philadelphia.

Thomas W. Fourqurean—has been named associate administrator, Methodist Hospital, Houston, Tex. Formerly assistant director, Hermann Hospital, Houston, he had also served as administrator, Brackenridge Hospital, Austin, Tex.

Alvin H. Goldberg—has been appointed director, finance and accounts, Maimonides Hospital of Brooklyn, N.Y. He was formerly comptroller, Beth Israel Hospital, New York City.

Also at Maimonides, **Harold A. Schneider,** formerly assistant director in charge of purchasing, has been assigned to executive office responsibilities. **Michael Marvald** has been named administrative assistant in charge of purchasing.

Thomas Gucker III, M.D. — has been appointed physician in charge, Rehabilitation Center, Orthopaedic Hospital, Los Angeles.

He was previously assistant attending orthopedic surgeon, Bryn Mawr (Pa.) Hospital, and assistant

(Continued on page 64)

Now...A Really PORTABLE Aspirator

THE JUNIOR TOMPKINS

Weighs only 16½ lbs.

$107.50

Complete with Yankauer suction tube and utility wrench

Cat. No. 100-65

COMPARE THESE FEATURES

- Totally enclosed heavy duty motor... requires no lubrication... rubber mounted to insure quiet, vibrationless operation
- 32 oz. suction bottle
- Simple filtering system...suction gauge and regulating valve
- Durable finish... Sklar two-tone baked enamel

Perfectly balanced... easy to carry

Sklar SKLAR PRODUCTS LONG ISLAND CITY, N. Y.

Sklar Equipment is available through accredited surgical supply distributors

CLASSIFIED

SHAY MEDICAL AGENCY

Blanche L. Shay, Director

Pittsfield Bldg., 55 E. Washington St.

Chicago 2, Illinois

POSITIONS OPEN

EXECUTIVE PERSONNEL: (a) Business manager. Southwest. Degree in accounting or business administration. Large hospital. $8,400 plus lovely home on hospital grounds. (HT-2462). (b) Personnel director. Middle West. 275-bed hospital. 600 employes. $7,200. (HT-2346). (c) Assistant business manager. Southeast. 500-bed hospital. (HT-2434). (d) Credit and collection manager. South, resort area. New, 50-bed hospital. (HT-2357). (e) Personnel director. Southwest. 500-bed teaching hospital. (HT-2195). (f) Purchasing agent. East. 500-bed hospital. (HT-2229). (g) Accountant-office manager. 100-bed hospital. East. 60-bed expansion planned. (HT-2226).

DIRECTORS OF NURSING: (a) Middle West. 135-bed hospital opened in December, 1957. $6,000 minimum. (HT-2496). (b) California. 100-bed hospital near Los Angeles. $6,600. (HT-2329). (c) Florida. 100-bed hospital, expanding. $6,000. (HT-1934). (d) Assistant. Middle West. 200-bed hospital, very progressive. $6,000. (HT-1226). (e) East. 160-bed hospital near Boston. No nursing school. $6,000 plus full maintenance. (HT-1759). (f) South. 325-bed hospital in city of 60,000. $7,200. (HT-2281).

DIETITIANS: (a) Chief. East. 175-bed hospital near New York City. $6,000. (HT-1305). (b) Therapeutic. Middle West. 125-bed hospital. Special diets and manage kitchen. $4,800 up. (HT-1942). (c) Chief. Middle West. 200-bed hospital, expanding. To $7,200. (HT-2046). (d) Senior administrative dietitian. Pacific Northwest. New 300-bed teaching hospital. Excellent opportunity for advancement. $5,650 to start. (HT-2240).

PHARMACISTS: (a) Staff. South. 300-bed hospital; 3 in department. (HT-2382). (b) Chief. Middle West. 325-bed hospital, expanding. $7,200. (HT-2021). (c) South. 200-bed hospital in city of 35,000. Work into position of purchasing agent for hospital. Excellent opportunity. (HT-2345). (d) Chief. Texas. Large city. 115-bed hospital expanding to 370 beds by next summer. Wonderful opportunity. $6,600 to start. (HT-2385). (e) Chief. South. 100-bed hospital. Some purchasing experience helpful. To $7,200. (HT-2197).

NOTE: We can secure for you the position you want in the hospital field, in the locality you prefer. Write for an application—a postcard will do. ALL NEGOTIATIONS STRICTLY CONFIDENTIAL.

WANTED: Sales representative who is well experienced in hospital equipment field, preferably with background in major operating lamp industry. A very good opportunity in an expanding firm. Remuneration commensurate with experience and ability. Applicant must be willing to relocate if necessary. Forward full resume of experience, background information, and photograph to: Box 502, HOSPITAL TOPICS, 30 W. Washington St., Chicago 2, Ill. All replies will be handled confidentially.

DIRECTOR OF NURSING SERVICE. 320-bed general hospital; fully approved, Joint Commission; interns and residents; School of Nursing. Prefer not over 45, Protestant, degree, experience in nursing service. Salary potential —$4,780 to $7,072 range, fringe benefits substantial. Apply Superintendent, Bethesda Hospital, Cincinnati 6, Ohio.

PERSONALLY SPEAKING

(Continued from page 62)

professor of orthopedic surgery, University of Pennsylvania School of Medicine, Philadelphia.

Chicago R.N. Chosen Illinois Nurse of Year

Evelyn Lundeen, R.N., head, premature center, Michael Reese Hospital, Chicago, was chosen as the Illinois Nurse of the Year by the Illinois Nurses' Association at its 55th annual convention, held in October in Chicago.

She was selected from among 13 other candidates, chosen earlier as district nurses of the year. **Belle Leighty, R.N.,** Quincy, received honorable mention for her contributions to health care of school children.

A pioneer in the development of methods for the care of premature infants, Miss Lundeen has been active in research and teaching since 1928. She helped develop successful feeding formulas, ways to control oxygen flow to incubators, and methods of maintaining rigid standards of cleanliness.

Co-operating with the Chicago Board of Health, she participated in a survey of nursing conditions in Chicago hospitals and helped develop a program for nursery care.

New officers elected by the Illinois Nurses' Association are: **Mrs. Louise A. Meyer, R.N.,** chief of nursing education, Illinois State Department of Public Welfare, Springfield, president; **Sister Delphine, R.N.,** St. Joseph's Hospital, Alton, first vice-president; **Adelaide Fritz, R.N.,** Chicago, second vice-president; **Aileen Mamlourg, R.N.,** Ottawa, secretary; **Hazel Brennenstall, R.N.,** Peoria, treasurer.

Charles E. Hall—has been appointed administrator, West Plains (Mo.) Memorial Hospital. He previously owned a laboratory in Jefferson City, Mo.

James L. Henry—has resigned as administrator, Park View Hospital, El Reno, Okla., to become assistant administrator, Baptist Memorial Hospital, now under construction in Oklahoma City.

Richard W. Hunsaker—has been appointed assistant administrator, Brockton (Mass.) Hospital. He was formerly assistant administrator, Children's Hospital, Columbus, O.

John P. Hyden—has been appointed personnel director, St. Francis Hospital, Evanston, Ill. Previously, he was on the faculty of Vanderbilt University, Nashville, Tenn.

Bernard J. Lachner—has been appointed associate administrator, Ohio State University Hospital, Columbus. He is a graduate of the University of Chicago program in hospital administration.

Mrs. Inez T. Lehbold, R.N.—has been appointed director of nurses, Jefferson Memorial Hospital, Festus, Mo. She was previously director of nurses, Jane Chinn Hospital, Webb City, Mo.

Diane Levin—has resigned as assistant public relations director, Michael Reese Hospital, Chicago, to join the public relations firm of Charles R. Feldstein and Co., Inc., Chicago.

C. Frederick Longshore—has been appointed personnel officer, Osawatomie (Kans.) State Hospital. He recently received a bachelor's degree in business administration from Washburn University, Topeka, Kans.

Joseph Marcovitch, M.D. — has been appointed superintendent, Jacksonville (Ill.) State Hospital. He succeeds **Louis Belinson, M.D.,** who resigned to become deputy

(Continued on page 143)

Single White Latex Examination Glove fits either hand. Small, medium, and large sizes.

Single Green Neoprene Examination Glove for persons allergic to natural latex. Small, medium, and large sizes.

Quixams®...

the Easy On-and-Off Examination Glove

A single glove fits either hand comfortably

Recommended for examinations, treatments, dressings

No sorting, any two of a size make a pair

the **PIONEER** Rubber Company

328 Tiffin Road, Willard, Ohio

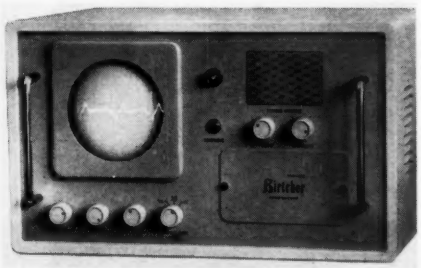
Pioneers in Surgical Hand Protection for over 35 Years

BUYER'S GUIDE

Ellen L. Davis

Buyer's Guide Editor

For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 152.



700. Electrocardioscope

New unit features a built-in audible signal, three trace speeds—1.5, 2.5 and 5.0 cm. per second—and a triggered sweep circuit which eliminates "ghost" images of previous tracings. A remote control box is provided for the cardioscope, together with an electrocardiograph, either or both of which may be located in another room if desired, allowing the anesthesiologist to switch leads and to put in the standardization pulse while seated in his normal place. An optional attachment provides for adding a second trace on the cathode tube, which can be used to display other events simultaneously with cardiac electrical activity. Birtcher Corp., 4371 Valley Blvd., Los Angeles 32, Calif.

701. Econocape

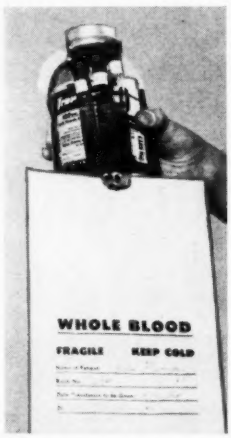
Made of extra-heavy, soft, single-ply crepe paper, this new low-priced item for examinations is designed to augment the line of corded capes, made of four plies of embossed facial tissue. Busse Hospital Products, 64 E. 8th St., New York 3, N.Y.

702. Patient lighting

Luminaire is a Single-unit ceiling fixture that provides three distinct types of lighting: a night safety light at the foot of the bed, a reading light directed at the head of the bed, and bed-length, shadowless flood-lighting for examination purposes. Can be surface-mounted or recessed in ceiling. Palco Mfg. Co., 1260 Pennsylvania Ave., San Francisco 7, Calif.

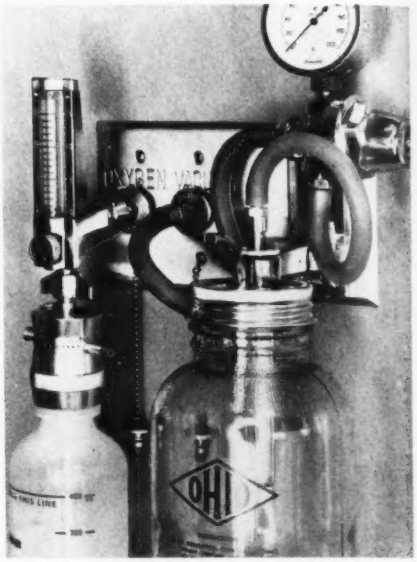
703. Plastibell

A time-of-birth circumcision device, the Plastibell is inserted following a dorsal slit in the foreskin. The suture is tied about the bell, the foreskin trimmed, and bell handle removed. The bell will fall off in 5 to 7 days; no special dressing or further care is necessary. Franklin C. Hollister Co., 833 N. Orleans St., Chicago 10, Ill.



704. Blood bag

Disposable bag for covering bottles of whole blood for transfusion is designed to help protect contents from dust and contamination. The outer ply of duplex bag is of white paper stock. Klean-Kan Bag Co., 64 E. 8th St., New York 3, N.Y.

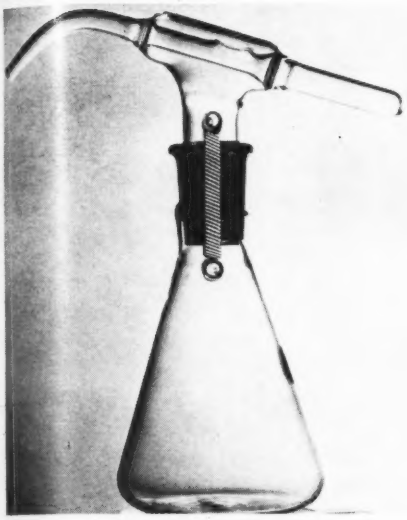


705. Piped oxygen outlet

Flush-mounted dual outlet incorporates both piped oxygen and vacuum line outlets in one wall box, features a slide bracket to hold a vacuum bottle, gauge, and vacuum control valve. Though the outlets are side by side, each service requires a separate safety plug-in adapter which is non-interchangeable. As an additional safety measure, each outlet is color-keyed for the gas handled. A. Schrader's Son, division of Scovill Manufacturing Co., Inc., 470 Vanderbilt Ave., Brooklyn, N.Y.

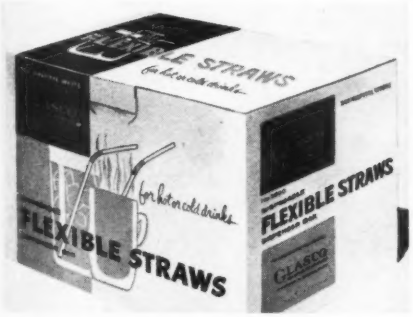
706. Truck bumper

New encircling bumpers are available as optional equipment on this line of platform trucks. The bumper offers greater protection for the truck itself, as well as for walls, doors, fixtures, and other surfaces. Extruded from a special non-marking gray rubber of proper resilience for maximum protection, the bumper is snap-inserted into a steel channel shaped to protect all sides of the truck. The Colson Corp., Jonesboro, Ark.



707. Volumetric pipetter

New unit consists of a Pyrex delivery head, and a Pyrex reservoir flask. Both are supplied with interchangeable ground glass joints and hooks for the attachment of connecting springs. Heads are available with a capacity range from 1 ml. to 100 ml. in any ½-ml. increment; flasks in 300-ml., 500-ml., 1000-ml., and 2000-ml. sizes. A flick of the wrist fills the pipetter head, and a forward tilt dispenses the accurate volume from the individually calibrated head. Palo Laboratory Supplies, 81 Reade St., New York 7, N.Y.



708. Flexible straw

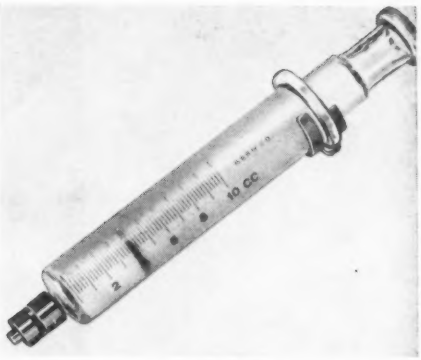
Flexible white drinking straws, designed especially for hospitals, are available in two styles: straws wrapped in a bactericidal paper and packaged in a sanitary box; unwrapped straws packed in a dispenser box. Of extra-sturdy paper, clinically wax coated, the straws bend in any direction for administration of hot or cold liquids. Glasco Products, subsidiary of Owens-Illinois Glass Co., Toledo, O.

709. Coplin jar

Non-tip Coplin staining jar is designed with a square base instead of the usual round type to allow alignment without wasted space. Holds up to ten 3″ x 1″ slides. Scientific Products, 1210 Leon Place, Evanston, Ill.

710. Tape

Clear plastic surgical tape combines hypo-reactive properties with "stretch" and conformity. Non-glossy surface is virtually invisible on the skin; waterproof and washable. In ½″, ⅞″, 1½″ widths. Johnson & Johnson, New Brunswick, N.J.

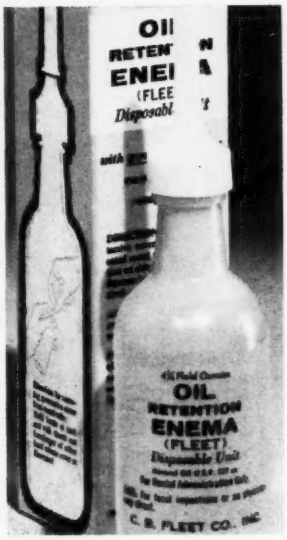


711. Interchangeable syringe

Made of heat-resistant Borosilicate glass, new interchangeable hypodermic syringe is specially treated with an exclusive process, which enables it to withstand sterilization at 250°. Air-tight, and with permanently etched graduations, the syringe is available in 7 sizes from 1 cc. to 50 cc. Kern Laboratory Supply Co., 8639 Venice Blvd., Los Angeles 34, Calif.

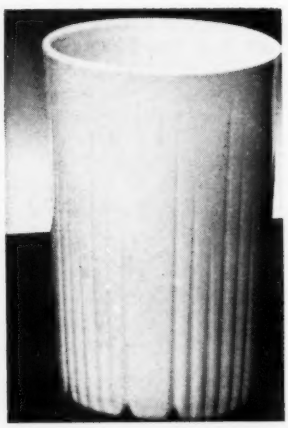
712. Surgical stool

Model MD-2HM rolls at a touch on spring-loaded casters. When weight is applied, safety domes over casters grip floor as casters retract, preventing rolling when stool is in use. Swivel casters are 1⅝″ conductive rubber ball-bearing type; 13″ diameter seat; 2″-thick foam rubber cushion with removable black rubber cover. Tubular steel base. Cramer Posture Chair Co., Kansas City, Kans.



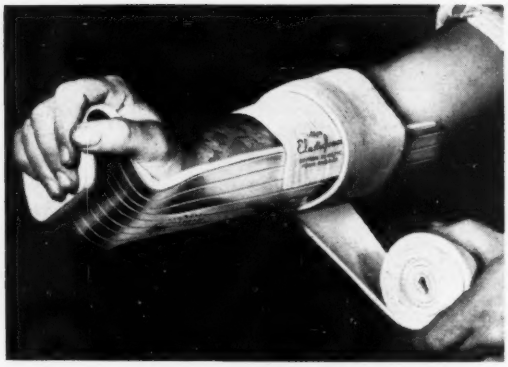
713. Enemas

Three ready-to-use Fleet enemas in disposable plastic squeeze bottles are available under the Bardic brand name: a phospho-soda formula 4½-oz. adult unit; new 2¼-oz. pediatric phospho-soda unit; and a 4¼-oz. retention type mineral oil unit. C. R. Bard, Inc., Summit, N.J.



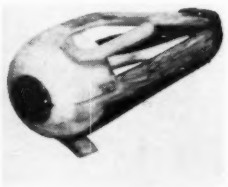
714. Plastic tumbler

Molded from high-density polyethylene, can be sterilized in autoclaves or washers without losing gloss; will not bend, break, or crack. For both hot and cold liquids. In 4, 5, 10, 12, 14-oz. sizes. Zylon Products Co., Inc., Pawtucket, R.I.



715. Alumafoam fence splint

Designed to fit any anatomical situation, the splint can be cut to desired length, and molded to fit the involved extremity or joint snugly. Forms in position in seconds, and can be used for simple fractures, infections, burns, and lacerations, and in local arthritis, for the relief of pain and effusion of joints. Elastifoam, cotton elastic foam rubber bandage, is recommended to hold splint in place. Splints available in 16″ lengths, in 2″, 3″, and 4″ widths. Conco Surgical Products, Bridgeport, Conn.



716. Eye model

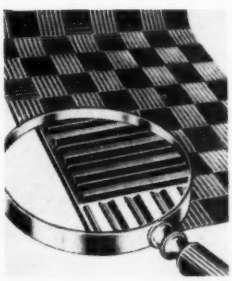
Can be separated into 6 pieces for detailed study, quickly reassembled. Mager & Gougelman, 30 N. Michigan Ave., Chicago 2, Ill.

717. Instrument cabinet

Harrison model cabinet for O.R. use combines ample storage space, easy maintenance of asepsis, and security. The upper section, enclosed by glass-paneled double doors, is available with either adjustable heavy glass shelves, or hooks welded to the back of the compartment, or a combination of the two. The lower compartment has three drawers and a storage cabinet with removable stainless steel shelf. Stainless steel construction, 36″ wide, 16″ deep, 78″ high; narcotic locker is 13¼″ x 5″ x 7¾″. S. Blickman, Inc., 8400 Gregory Ave., Weehawken, N.J.

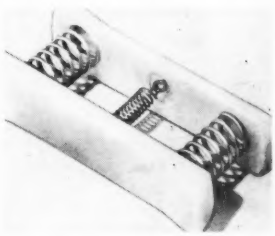
718. Mat

Rugs and runners in black, red, green, tan; in grey and white in grease-and-chemical-proof Niru material. V-shaped rib. Wear Proof Mat Co., 2156 W. Fulton St., Chicago, Ill.



719. Aluminum sink

Unbreakable cast aluminum sink, smoothly contoured, and finished in glossy, non-chip white or pastel colors. All standard models, and one-piece washbowl and toilet combinations available. Aluminum Plumbing Fixture Corp., 778 Burlway Rd., Burlingame, Calif.



720. Exerciser

Big-Grip exerciser builds strength and co-ordination in hand, wrist, and forearm. Contour-shaped polystyrene handles; lifetime springs calibrated in pounds of pressure to 10, 15, 30, and 60 lbs. Rehabilitation Products, division of American Hospital Supply Corp., Evanston, Ill.

721. Dia-Pump

New 21-lb. unit is a low-volume diaphragm pump that provides continuous pressure and suction for applications requiring delivery of oil-free air. Operates with Form G motor, rated 1/6 horsepower at 1725 rpm. General Electric Co., Schenectady 5, N.Y.

Pelton & Crane

SOUNDS A NEW HIGH NOTE IN ULTRASONIC CLEANING

THE PEL-SONIC WASHER & DRYER

Following months of an intensive research and development program, Pelton & Crane announces the new **PEL-SONIC WASHER & DRYER** for hospital use . . . at a fraction of the cost of similar equipment.

With the **PEL-SONIC WASHER & DRYER,** small utensils, instruments, glassware become microscopically clean, ready for sterilization *in just minutes.* Ultrasonic energy is generated by passing alternating current through transducers of barium titanate, which then direct sound waves into the liquid detergent bath. No water cooling is required, hence no plumbing connection . . . and no special wiring. As sound waves travel through the solution, cavitation sets in, literally cleaning contaminated areas with fierce, agitated action . . . yet ultrasonic action is completely gentle and safe, even to the most delicate surfaces. And instruments emerge spotless . . . stainless.

The **PEL-SONIC WASHER & DRYER** save you space. Made of stainless steel, each unit measures a compact 18 x 21" – completely portable, ready for use anywhere throughout the hospital. The instrument basket is roomy enough to hold more than 100 instruments at a time . . . including sponge forceps, hemostats, needle forceps, syringes.

Anyone can learn the easy-to-operate controls quickly. Add one ounce of **PEL-SOL SURGICAL DETERGENT** to a gallon of water, turn on switch, insert basket and set the automatic timer . . . from 5 to 10 minutes, depending on the degree of contamination.

For continuous best results, always use **PEL-SOL,** a guaranteed blood and pus solvent, the recommended detergent for the **PEL-SONIC WASHER & DRYER. PEL-SOL** solution is reusable – for repeated cleanings. You change it manually, only when the solution becomes cloudy. Order it from your surgical supply dealer. **A TIME, MONEY & LABOR SAVING ADVANCE!**

The **PEL-SONIC WASHER & DRYER** belong in all modern hospitals. They will pay for themselves in a few weeks in extra time available to personnel.

USE THE COUPON BELOW FOR FREE DESCRIPTIVE LITERATURE OR A DEMONSTRATION

THE Pelton & Crane COMPANY

Charlotte 3, North Carolina

Professional equipment since 1900

THE PELTON & CRANE COMPANY
Charlotte 3, North Carolina, Dept. T

I am interested in the new PEL-SONIC WASHER & DRYER.

☐ Please send me descriptive material.

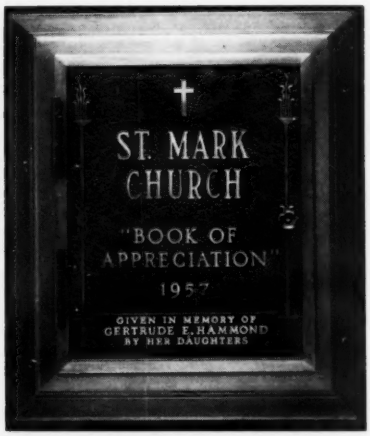
☐ Please have your representative phone for an appointment to demonstrate.

NAME (HOSPITAL).....

PERSON TO PHONE..... **PHONE NO.**.....

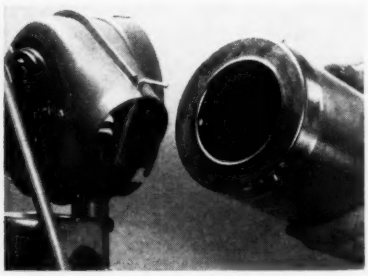
ADDRESS.....

CITY..... **STATE**.....



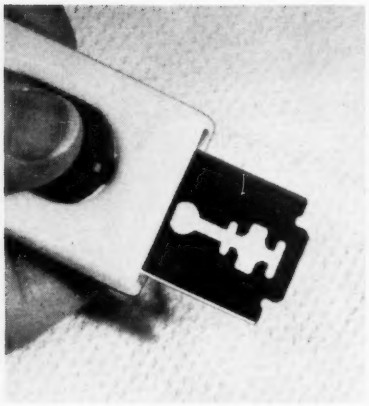
722. Memorial book

A permanent memorial, *The Book of Appreciation* has hand-tooled cast bronze cover, with hinged door; desired inscription is in raised, burnished letters. Available in 2 sizes: 25″ x 32″ with space for 3,250 names of donors and contributors on copper pages with letters etched in relief; and 15″ x 18″ allowing for 1,050 names. Newman Brothers, Inc., 660 W. 4th St., Cincinnati 3, Ohio.



723. Kleen-Air odor tent

Mechanism, which utilizes activated carbon for removal of offensive hospital odors, has a tubular frame attached to small, explosion-proof motor mounted on a blower frame with an adjustable vent to control air flow over patient. A perforated metal cylinder containing carbon granules fits into the unit. A plastic tent, with a sleeve for the cylinder, is partially placed over patient. All air blown through the tent must pass through a deodorizer before recirculating through the room. Howard S. Caldwell Co., Lancaster, Ohio.

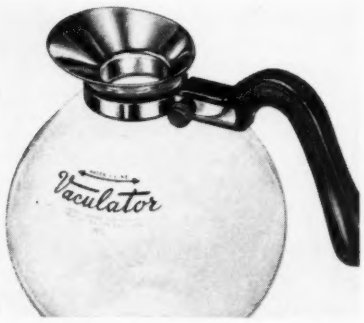


724. Blade dispenser

Tomac razor blade dispenser pack dispenses one blade at a time right onto the razor, eliminating danger of cutting fingers. Unit holds 20 precision-sharp blades of .005 surgical steel, and has slot in back for storage of used blades. American Hospital Supply Corp., Evanston, Ill.

725. Ice maker

Completely automatic unit eliminates pans and trays. Round cubes are individually frozen from cascading water, which purifies and removes minerals and salts. Makes up to 45 lbs. of ice per day, cubes being automatically stored in a 35-lb. capacity stainless steel bin. American Automatic Ice Machine Co., 2100 Park Ave., Faribault, Minn.

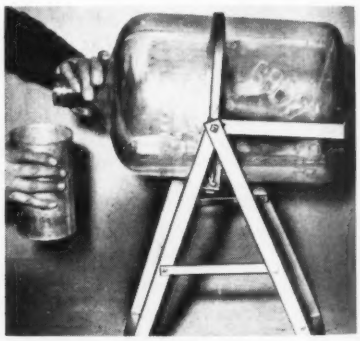


726. No-chip decanter

A full year's warranty against lip or neck breakage is currently in effect on Vaculator decanters. Stainless steel armor protects pouring surface even when hit against water faucets or marble counter tops. Wide pouring lip has no-drip cutoff. Hill-Shaw Co., 311 N. Desplaines St., Chicago 6, Ill.

727. Wall switch

New wall switch is a straight-sided, rectangular wall plate that frames a large actuator. User turns light on by touching the top of the actuator, off by touching the bottom. Made to mount in standard wall boxes, the switch is available in 15- and 20-ampere ratings for use on alternating current where the voltage ranges from a nominal 120 volts to 277 volts. Bryant Electric Co., Bridgeport, Conn.

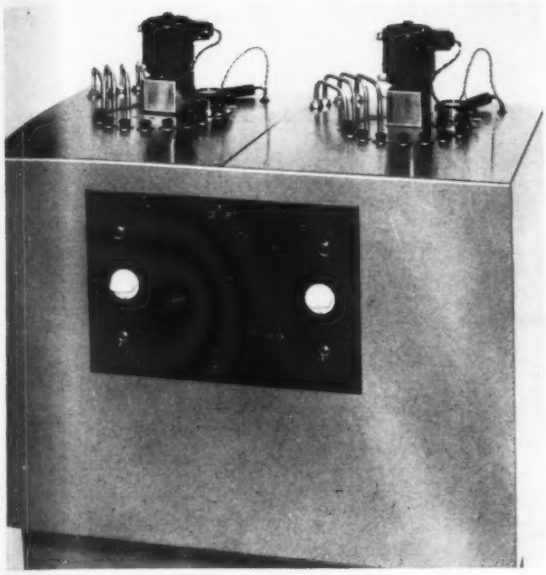


728. Container stand

New Tilt-Right unit holds round or rectangular bottle, can, or drum, with adjusting device to assure snug fit. Rocker frame permits single-handed tilting and pouring from desired position. Measures 20″ x 16″ x 16″ in working position; folds to 1″-width for storage; all adjustment is controlled by a single wing nut, requiring no tools. Paul O. Young Co., Line Lexington, Pa.

729. Garbage and refuse disintegrator

Pagar disintegrator can consume 300 lbs. of garbage, paper, and other refuse per hour, reducing it to an odorless, insect- and rodent-proof mass which can be used as a valuable organic soil conditioner. The use of stainless steel, which resists food acids, salt, and other ingredients, helps keep machine in good working order, reduces exterior maintenance. Meili and Worthington, Inc., Hatboro, Pa.



730. Thermometer calibrating bath

New double-unit bath allows operator to calibrate simultaneously a large number of thermometers at two different temperatures. Two separate, completely equipped baths, integrated into a single cabinet, develop temperatures ranging from 6°C. above room temperature to 260°C., with a constancy of plus or minus 0.2°C. American Instrument Co., Inc., 8030 Georgia Ave., Silver Spring, Md.

731. X-ray amplifier

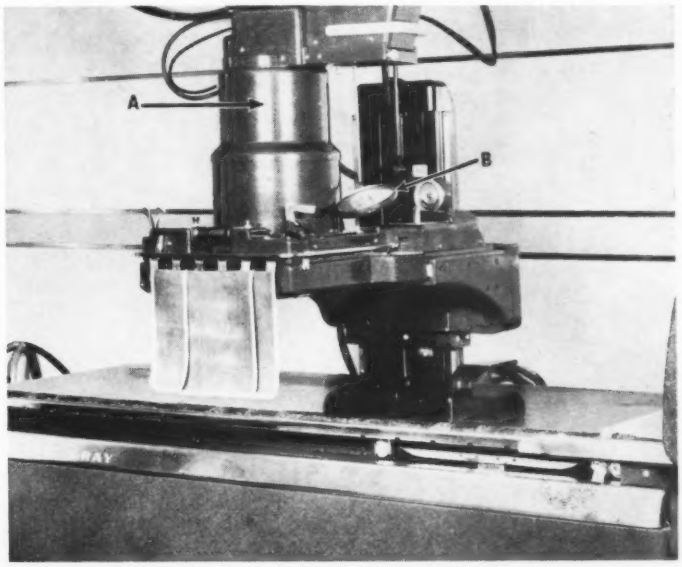
New x-ray device permits substantial reduction of total radiation to patient; provides image 350 times brighter than fluoroscope; permits viewing of entire pulsing adult heart, stomach, colon, and other organs; permits detailed visual study of deep tissues. The pick-up screen of the image tube supplies a usable area of 41 sq. in., enabling advanced studies, including heart catheterization. The x-ray equipment, developed by Picker X-Ray Corp., Cleveland, O., to house the image tube, is flexible so that the physician can place the patient in virtually any position. Brightness of image on amplifier tube allows decrease of x-ray intensity. Closed-circuit TV chain linked to the x-ray equipment. The Rauland Corp., 4254 N. Knox St., Chicago, Ill.

732. Jet-steam cooker

New high-compression steam cooker provides steam at 15 lbs. per sq. in. gauge pressure in 45 seconds; begins cooking immediately timer dial is set. Humidity control provides either a moist or super-heated steam when cooking starts. Water input is automatic, and adjusts to the size of the load, the steam exhausting itself when correct cooking time is reached. Hotpoint Co., 6201 W. Roosevelt Rd., Berwyn, Ill.

733. Mechanical convection oven

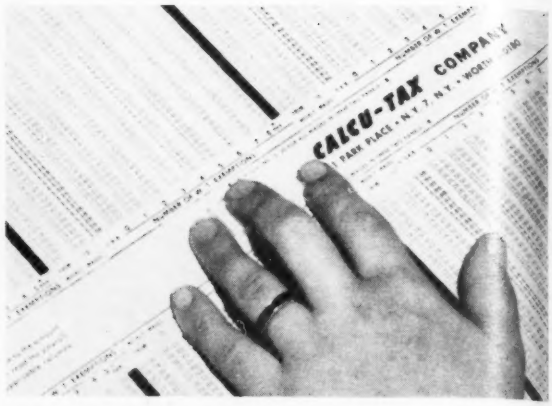
Laboratory oven control in the near furnace temperature range is available in new Precision-Freas oven, which has an electronic resistance thermometer circuit to provide a range of 125° to 1000° F. Mechanical convection and controlled directional air flow give temperature uniformity throughout the working chamber of ± 1° at 125° F., and ± 6° at 1000° F. Precision Scientific Co., 3737 W. Cortland St., Chicago 47, Ill.



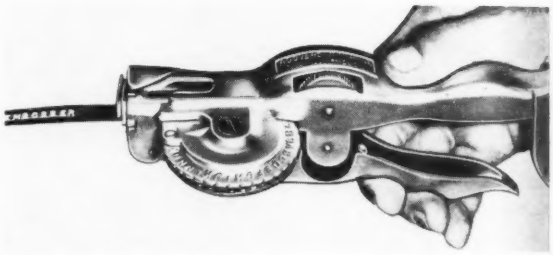
734. Imbedment panel

Formerly available only as a custom item, new flat decorative panel employs standard mass production methods of the fiberglas industry. In 3 weights and 3 designs—fern, garden, and maple—the shatterproof panels utilize foliage, grasses, and real butterflies on smooth-surfaced mist white Alsynite. For shower doors and tub enclosures where public safety is a factor. Alsynite Company of America, 4654 De Soto St., San Diego 9, Calif.

735. Micro-Filter for Isolette

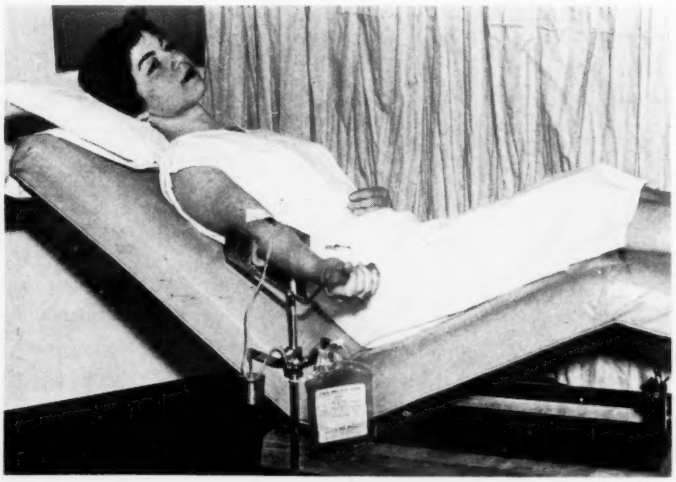
New air filter is available for use on the Isolette infant incubator to remove contaminants from hospital nursery air, and to help minimize danger of air-borne infections in the premature nursery. The incubator has a system of forced circulation of air from outside the hospital; no nursery air enters, since there is always a slight flow of air outward from the Isolette. Equipped with the new Micro-Filter, the Isolette now provides complete isolation even when not connected to an outside air source. According to the manufacturer, laboratory studies show the filter to have an efficiency of 99.5% in removing particles varying in size from 0.5 micron to 3.4 micron with a mass median diameter of 1.7 micron. Micro-Filter assembly includes cast aluminum filter body, plastic cover, oxygen input nipple, fasteners for installation on any Isolette, and one dozen filter pads. Air-Shields, Inc., Hatboro, Pa.

736. Payroll tax computer

Calcu-Tax is designed to reduce sharply the time required to prepare weekly payrolls. It shows withholding tax, and the new 2½% Social Security deductions all on one line for wage brackets up to $250. No special skill or practice required for its use. Replacements available as tax rates change. Calcu-Tax Corp., 49 W. 37th St., New York 18, N.Y.



737. Hand labeler

New labeler embosses permanent, raised lettering and numbers on ½"-wide strips of corrosion-resistant monel, stainless steel, aluminum, copper, lead, and vinyl plastic. Colored vinyl plastic or metal strips with pressure-sensitive adhesive backing also available. Roovers-Lotsch Corp., 3611—14th Ave., Brooklyn 18, N.Y.



738. Blood donor lounge

New blood donor unit has an adjustable contour shape to help eliminate tenseness on the part of the donor. Upholstered in Boltaflex Palomino, leather-like vinyl material in bright decorator colors for easy washability and wear-resistance as well as cheerful appearance. According to the manufacturer, statistics show the lounge reduces loss of blood units due to donor fainting by about 60%. Because the donor's experience is one of relaxed, comfortable donation, he is more likely to become a regular donor, and influence others to do likewise. Boston Spring Bed Manufacturing Co., 483 Southhampton St., Boston, Mass.

739. Linen marker

Machine for marking hospital linen and apparel uses quick-change dies or stock plates that can be embossed by hospital or addressograph company. Thermak Tape provides fresh surface for each imprint; temperature, time and printing pressure controlled by built-in features. Textile Marking Machine Co., Inc., 2204 Erie Blvd. E., Syracuse, N.Y.

742. Sensi-disc dispenser

A new dispenser, a companion product to the Sensi-Disc line of antimicrobial sensitivity discs, is available. Dispenser releases up to 8 discs simultaneously to form a uniform pattern on prepared, standard-size Petri dishes. A lever releases discs from the unit's cartridge, which contains 50 discs. The bacteriologist is free to select any group of antimicrobial agents for various types of specimens or micro-organisms. The dispenser also minimizes contamination from handling of discs. Baltimore Biological Laboratory, Inc., division of Becton, Dickinson and Co., Rutherford, N.J.

743. Protective cream

Kerodex, new barrier cream for face, hands, and body, fits like an invisible glove, protecting against acids, alkalis, dyes, and other skin irritants. Hands coated with cream and immersed 1 minute in hydrochloric acid were unharmed in test, according to manufacturer. Ayerst Laboratories, 22 E. 40th St., New York 16, N.Y.

744. Storage hut

Kemhut, 10′ wide, 12′ long, 7′ high storage building, is made of fiberglas reinforced translucent plastic panels. Assembled in several hours, it needs no bracing, is vermin-proof, unaffected by mild acids and alkalis. Interior can be hosed for cleaning. Kemlite Corp., 101 N. Republic Ave., Joliet, Ill.

745. Plaster of Paris

Imported from Denmark, Stucca bandage is fine grain plaster and binder uniformly distributed throughout close mesh gauze. Binder prevents dust annoyance when dry, prevents plaster from running during immersion. In 2″, 3″, 4″, and 6″ by 3-yd. sizes. Acme Cotton Products Co., Inc., 245 Fifth Ave., New York 16, N.Y.

740. Shelving

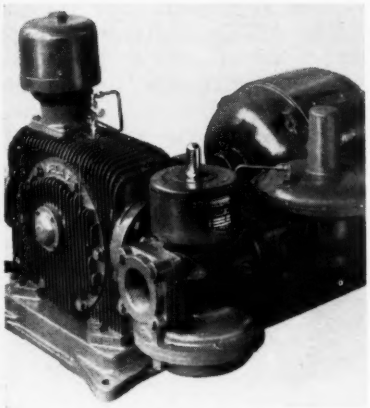
Complete line of boltless shelving features new channel clip. The male part of the clip has two stamped T's that insert through the holes in the upright angle post. The female unit slides over the T's, clamping both parts firmly in place. Penco Division, Alan Wood Steel Co., 200 Brower Ave., Oaks, Pa.

741. Oxygen tank

Completely equipped hand unit features a precision engineered pressure reducing regulator to permit oxygen flow easily and safely. Twist of the wrist turns it on and off; tank is replaced in 30 seconds. Tanks, regulator, mask and hose come in plastic case. Oxygen Equipment & Service Co., 8335 S. Halsted St., Chicago 20, Ill.

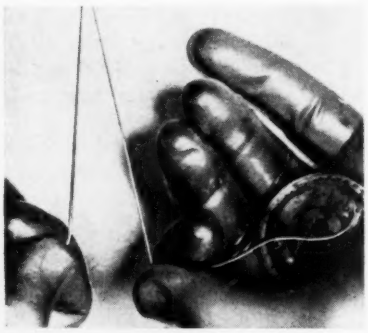
746. Fork lift truck

New line of Dynamotive gas powered, electric driven fork lift trucks have capacities ranging from 4,000 to 10,000 lbs., with lifting heights to suit all applications; travel speed of 8.5 m.p.h.; lifting power of 4,000-lb. loads up to 75 f.p.m. Dynamotive drive principle eliminates need for clutch, fluid coupling, fluid torque converter, or multiple speed transmission, reducing maintenance costs and repair parts inventory. Automatic Transportation Co., 149 W. 87th St., Chicago 20, Ill.



747. Propane diluter

New unit automatically supplies accurate mixtures of propane and air, or butane and air, to maintain heat and refrigeration during periods of fuel cutoff. Available for small, medium, and large installations, diluters provide simplified interchangeability by connecting to existing gas piping without adjustment to appliances or gas burners. Selas Corporation of America, Dresher, Pa.



748. Surgical suture

New patented "cold" process sterilization is now being used for Curity catgut sutures. The cold method employs ethylene oxide gas in a minute liquid form that sterilizes in a sealed container, leaving original strength of catgut substantially unaltered and giving tissue retaining power without extensive tanning procedures, according to manufacturer. Bauer & Black, division of The Kendall Co., 309 W. Jackson Blvd., Chicago 6, Ill.

749. Aluminum foil

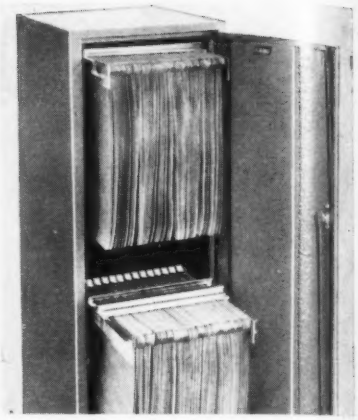
New 10-lb. roll of aluminum foil, protected by heavy cardboard carton, is self-dispensing. Available in widths of 12″, 15″, and 18″ in gauges .0007 (light), .001 (medium), and .0015 (heavy). Kaiser Aluminum & Chemical Sales, Inc., 1924 Broadway, Oakland, Calif.

750. Cylinder cart

New space-saving cart stores cylinders in space 18″ x 24″ x 24″. Unit consists of two semi-pneumatic tires, and two 360-degree swivel casters mounted on welded base that fits around the lower part of the cylinder. Low center of gravity prevents tipping. Carrier has no handles, is moved by pressure on upper part of cylinder. For placing or removing cylinder, the rear casters are raised until base-plate is at floor level. National Cylinder Gas Division, Chemetron Corp., 840 N. Michigan Ave., Chicago 11, Ill.

751. Light duty caster

New floating hub caster with special light-duty spring is designed for handling of delicate equipment, electronic instruments, liquids, and other fragile loads. Soft rubber tread absorbs shocks, snubs out vibrations, reduces noise; spiral spring allows hub and wheel to "float" over bumps. Bassick Co., Bridgeport 5, Conn.



752. Vertical file

Vertiflex pocket file system for negatives, plates, stencils, and x-rays consists of special Kraft envelopes that accommodate material up to 24″ x 30″, vertically suspended from flexible aluminum hanger blades. Ninety-six files fit in one foot of wall space. Plan Hold Corp., 5204 Chakemco St., South Gate, Calif.

753. Disposable decanter

Disposable decanter transfers liquids under protective layers of oil; decants contaminated, stratified, and radioactive liquids safely. The ends of the Nylaflow tubing, only part of the unit that contacts the liquid, can be cut off and disposed of after use. J-Line Products, Minneapolis 20, Minn.

754. Measuring pitcher

Boilable, shatter-resistant 32-oz. measuring pitcher with built-in markings is molded of polymethylstyrene plastic. Graduations indicate measurements by the cup, ounce, cubic centimeter, pint, and quart. Patented no-drip, hook-on pouring spout fits over bowls and jars, eliminating need for funnel. Formulette Co., Inc., Jamaica, N.Y.

Packaging papers for Johnson & Johnson guaranteed sterile hospital dressings undergo a battery of exacting physical and biological tests.

One test, the recontamination chamber (above), bombards paper samples with bacteria-sized particles to measure porosity.

guaranteed sterile Patient-Ready dressings

ACHIEVED through research

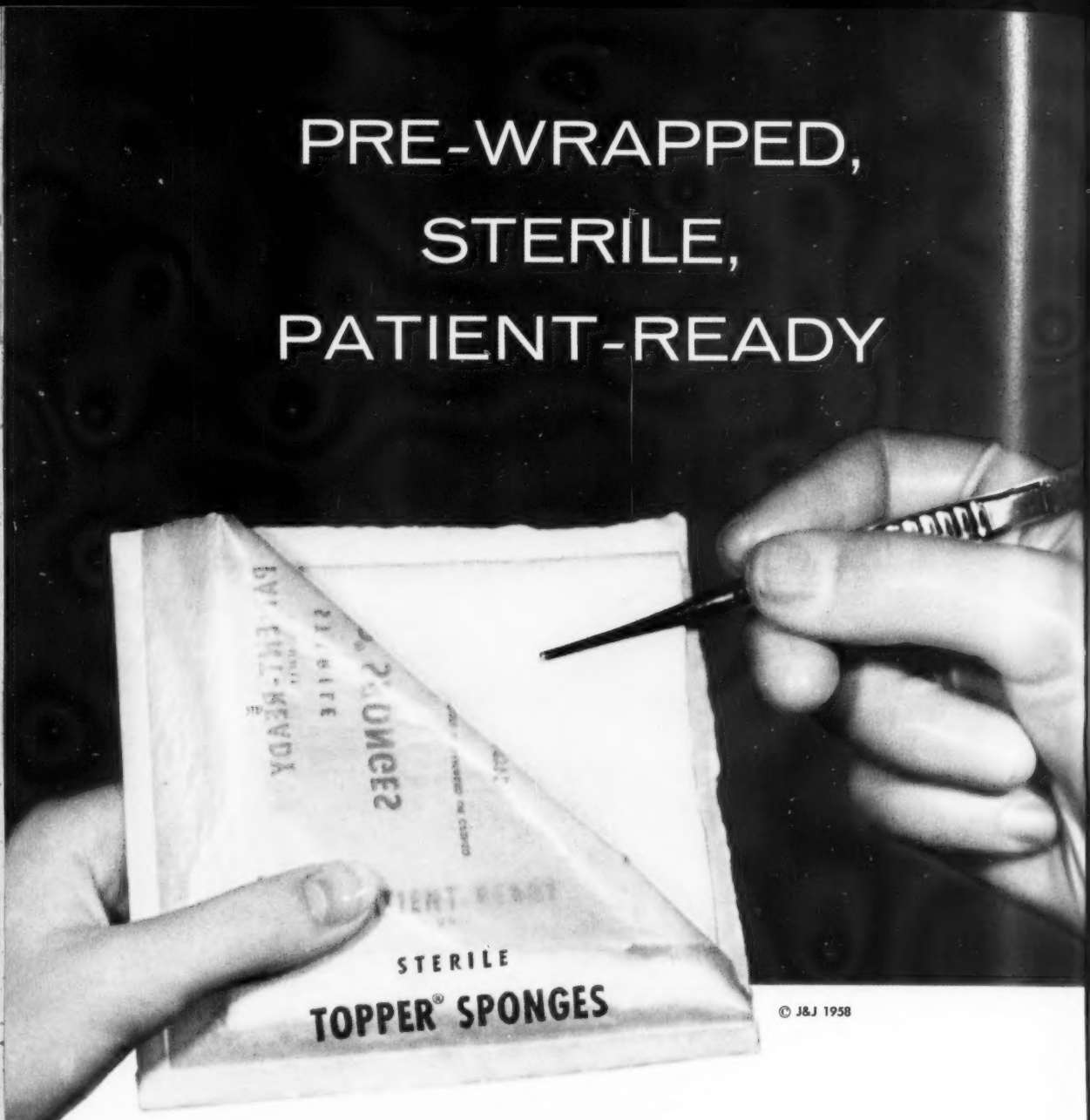
PACKAGED by modern equipment

STERILIZED with advanced techniques

MAINTAINED by continuous testing

Johnson & Johnson

PRE-WRAPPED, STERILE, PATIENT-READY



© J&J 1958

TOPPER® SPONGES

A highly absorbent sponge composed of a filmation of downy-soft cotton and cellulose enclosed in gauze.

THE MOST TRUSTED NAME IN STERILE SURGICAL DRESSINGS

Johnson & Johnson

FILMS, NEW LITERATURE

760. Laboratory glassware

New 20-page catalog gives specifications and prices of the expanded line of Lab-Crest glassware featuring the leakproof, freezeproof stopcock that requires no grease. Fischer & Porter Co., 195 Jacksonville Rd., Hatboro, Pa.

761. Gas sterilization

Catalog *Section 5* describes a new line of completely automatic, low temperature gas sterilizers. The sterilizers are available as self-contained units, or the Sterox-O-Matic control system may be adapted to existing bulk installations for use with gas alone, or with steam and gas alternately. Wilmot Castle Co., 1921 E. Henrietta Rd., Rochester, N.Y.

762. Ultracentrifugation

An Introduction to Ultracentrifugation Techniques, illustrated with photographs and curves, is intended to provide a basic understanding of the function and applications of the analytical ultracentrifuge. Text covers the three technics of sedimentation velocity, sedimentation equilibrium, and approach-to-equilibrium by means of which measurements and calculations concerning the various physical properties of solute molecules can be made. Spinco Division, Beckman Instruments, Inc., Stanford Industrial Park, Palo Alto, Calif.

763. Tapes

Over 435 pressure-sensitive tapes of various sizes, colors, and patterns for making graphs, organization and flow charts, layouts, and other presentations, are illustrated in 32-page booklet, *Visualization Made Easier.* Among new items listed are transparent colored tapes, and tapes as narrow as 1/64". Chart-Pak, Inc., Leeds, Mass.

764. X-ray microscope

New 6-page folder, *A High-Resolution PMR X-ray Microscope with Electron Microscope Conversion,* gives scientific details on the new instrument—an x-ray microscope which determines the chemical composition of the specimen. Illustrated with photos, diagrams, and micrographs. Instruments Division, Philips Electronics, Inc., 750 S. Fulton Ave., Mount Vernon, N.Y.

765. Hot water heat

Full-color file sheet No. 3460 describes new direct oil-fired hot water heater. Three models, all with 30-gal. reserve tanks, and completely packaged ready for installation, are available to heat 135, 200, and 270 gals. of water per hour. Petro, 3170 W. 106th St., Cleveland 11, O.

766. Disaster tags

Literature describes the new standardized form of disaster tag, which is made in triplicate, with a length of cord for tying to the victim. Interleaved carbon copies are provided for the admitting department and information center. Back of tag provides for a condensed record of treatment. Physicians' Record Co., 161 W. Harrison St., Chicago 5, Ill.

767. Stretcher system

New 6-page folder describes Transaver stretcher system, designed to provide safe transportation of stretcher patients. The stretcher—not the patient—is moved for surgery and for all diagnostic procedures, including x-ray examination. Brooks & Perkins, Inc., 1950 W. Fort St., Detroit 16, Mich.

Advertisement

CARDIOLOGY

Electrocardiogram Accuracy

Not every physician needs the exquisite accuracy obtainable with the new Birtcher Electrocardiograph.

At present probably only about one physician in several hundred is sufficiently versed in cardiographic interpretation to appreciate the extraordinary refinements of cardiac electrical activity recording, and thus to comprehend the real character of this instrument's traces.

Fewer still are the number of those physicians, qualified by training in physics and engineering, to understand the functioning of so complex an electronic device as the direct writing Electrocardiograph.

The Birtcher was conceived and executed to surpass the most rigid specifications set up by various august cardiological bodies and governmental groups.

Not a single compromise has been made in accuracy of this direct writing instrument, in order to gain quick acceptance and promote rapid sales. Not one iota of known engineering for accuracy has been prostituted to satisfy those "customers" whose apparent requirements are based on a lack of knowledge or actual false information. Not a single sacrifice in engineering integrity has been made to cater to the salesman...nor for the sake of a lower price.

The design, nourished by the devoted guidance of a distinguished panel of cardiologists and cardiographers, in no manner reflects the personal professional idiosyncrasies of individuals, at the cost of impairment of principles.

The Birtcher Electrocardiograph, presented with courage and dignity, engendered by integrity to provide a professional lifetime of dependable, accurate cardiography, anticipating new methods and concepts in cardiology and cardiography yet to come, costs somewhat more...Yet, in four short months since its introduction, it has proven itself the hard way from coast to coast and in about twenty foreign countries as well, and it is firmly established among quite a number of those most eminent in cardiography.

Although the Birtcher is purveyed through surgical supply dealers, only those who, through special experience and training in such electronic devices and are otherwise qualified to render service, have been selected to have the Birtcher franchise.

A physician, by simple request on his letterhead or Rx blank, may receive without further ado, a large, five color brochure descriptive of the Birtcher Electrocardiograph and, as a gift, a new, special dual speed ECG measuring rule, together with a new booklet on cardiographic diagnosis, both especially prepared for Birtcher by a distinguished cardiographer. Please address your request to: The Birtcher Corporation, Department HT-1158, 4371 Valley Boulevard, Los Angeles 32, California.

TOPICS Takes Camera Tour of

All photos by Hospital Topics

Use of the Sigmamotor cross-circulation pump in open-heart surgery is explained by Phillip Slattery (r.), Sigmamotor, Inc., to Wolf Sapirstein, M.D., Toronto, Ont., Canada. Model T-M2 is fourth major modification since first unit was developed in conjunction with C. Walton Lillehei, M.D., and associates at University of Minnesota. Company says unit has improved noise level and ability to accurately calibrate pumping capacities. More compact than previous models, unit is 33" long, 9¾" wide, 12½" high. Net weight: approximately 140 lbs. Two pumping heads are incorporated into single unit. Direction of flow in two pumps is opposed. C-780.

Left: Wrap-around chest respirator has a light, pliable plastic garment, which is placed over patient to effect the air-seal, and a shell arched over the chest and abdomen, to hold garment away from body. Shell rests on bed, not on patient. Intermittent negative pressure is provided by model CRV pump, which operates on 110-volt, 60 cycle, AC. J. H. Emerson Co. C-781.

Right: Electrically conductive cardiac suture, introduced at meeting by Ohio Chemical & Surgical Equipment Co., is shown here by L. E. Runkel, Ohio Chemical, to Henry Robbins, M.D., Lincoln, Knickerbocker, and Misericordia Hospitals, New York City. Wire electrode is applied directly to the myocardium. Chest incision can then be closed and electrical stimulation still maintained. Silver wire is armed with swaged needles, one curved and one straight. A single stitch is taken in the ventricular myocardium with the curved needle. Straight needle is placed in chest wall and attached directly to the pacemaker attachment. Suture is supplied in sterile packets. C-782.

ACS Exhibits

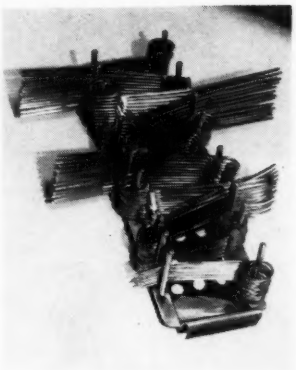
Pictured on these pages are some of the newest products in the hospital and medical fields which were shown, for the first time in some cases, at the 44th annual clinical congress of the American College of Surgeons, held in Chicago, October 6 through 10. During the congress, more than 140 firms displayed their products in the technical exhibition, held at Chicago's Conrad Hilton Hotel.

Top, right: Gil Frommelt (r.), Orthopedic Equipment Co., shows new Smith-Petersen nail rack to Franklin Norris, M.D., Orange Memorial Hospital, Orlando, Fla. Stainless steel, non-tippable rack holds 12 No. 96 Smith-Petersen nails for hip fixations, and 6 bolts, or Smith-Petersen nail extension. During 6-month introductory period, the nail rack will be given free with purchase of one dozen nails. Available only through local surgical supply dealers, rack is 3" x 6", fully autoclavable. C-783.

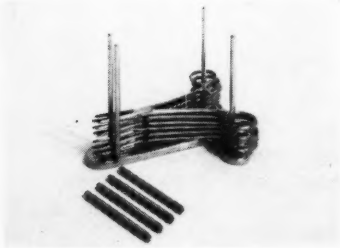
Above: Curon, new elastic foam bandage which clings to itself, was introduced at ACS congress. Here Ed Marlotte (l.), Surgical Products Division, American Cyanamid Co., demonstrates application of bandage on wrist of Philip S. Luedde, M.D., St. Mary's, Lutheran, and Firmin Desloge Hospitals, St. Louis. Bandage is lightweight, porous, elastic foam which is said to be physiologically inert. C-784.

Features of new Dri-Clave 150, dry-heat sterilizer, are explained by E. Philip Fortuna (r.), Grieshaber Manufacturing Co., and Herman Grieshaber (center) to Donald E. Bowes, M.D., who was going from the congress to join the staff of the United Christian Hospital, Lahore, West Pakistan. Sterilizer is equipped with three full-size instrument trays, tray handle, adjustable precision thermostat, thermometer, built-in timer, two signal lights. Stainless steel housing; polished aluminum interior. C-785.

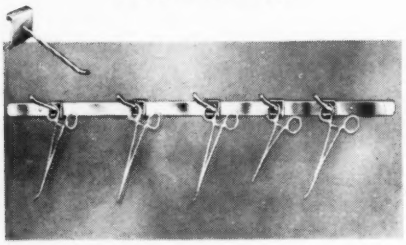
Fine Instruments Deserve Fine Care



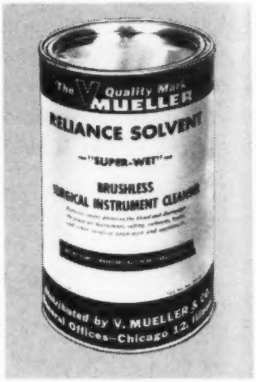
KIDD INSTRUMENT RACK



HAGIE T-STACK



ADJUSTA-RACK



MUELLER RELIANCE SOLVENT

ABOVE, are a few of the ingenious, but simple devises offered by V. Mueller to make it easy for you to give your instruments the best care.

The new KIDD INSTRUMENT RACK . . . the perfect way to sort, sterilize and store your artery forceps. Holds 60 to 75 forceps with jaws open. Overall length is 15⅜" to fit 16" sterilizing chamber. Store as sterile pack until needed.

SU-E2985 KIDD Instrument Rack—each **$17.50**
Dozen **$189.00**

The HAGIE T-STACK . . . adjustable, threaded pins permit set-up for various forceps sizes. Holds 12 or more forceps of a size or type. Stainless. Sterilize with instruments. A space-saving organizer in storage cabinets.

SU-E2980 HAGIE T-Stack .....Each **$6.50**

The ADJUSTA-RACK . . . fits itself to your storage problems. Easily mounted on wall or cabinet. Nonslip hangers hook on, lift off, but can't fall off. Sterilizable. Standard size 36", but supplied in any length. 3 hangers per foot. Specify exact length and center-to-center distance between mounting holes.

SU-E2950 ADJUSTA-RACK, 36" length,
9 hangers .....Each **$9.75**
Additional hangers or extra foot of length **60c**

MUELLER RELIANCE SOLVENT . . . cleans everything surgical without scrubbing or brushing. Super-Wet, quickly and safely dissolves blood and tissue. One ounce makes one gallon of fast-acting, reusable solution. Harmless to hands.

H.S.-D588 per 5# can.....**$5.50**
Case lots (6) each..... **5.00**

V MUELLER & CO.
330 South Honore Street
Chicago 12, Illinois
Dallas • Houston • Los Angeles • Rochester, Minn.

Armamentarium

The Pharmacy

Stopping *Phone Jangle* in the Pharmacy

By E. Byron Smith*

• All morning long—every morning—the telephone rang in the pharmacy department of Good Samaritan Hospital, Portland, Ore.

"I've got a 'stat' order on the dummy," a nurse would say.

Or "Please hurry with the elastic bandage; the doctor is waiting."

And again: "Will you please see whether you have an order for Mrs. Jones' Dilantin? She's in 462."

No doubt the scene is a familiar one to many hospital pharmacists. And at our 460-bed institution, it seemed as though the situation only got worse; it never got better.

The phone calls—many of them unnecessary—were not only time-consuming; they also interrupted the pharmacists' train of thought, and increased the possibility of human error.

One day, the problem seemed about to reach a climax when the hospital maintenance man reported that the following day the pharmacy elevator would be out of use during repairs. The dead elevator, the very much alive phone, a full surgery schedule, and an unusually high percentage of "sick" patients on the medical floors, combined to give the next day a unique potential for telephone pandemonium.

But as the day's activities began, no telephone calls came. Not at 8 o'clock when the pharmacy opened; not at 9 o'clock; not even at 10.

One or two nurses appeared at the pharmacy door for medications which were urgently needed; others called there for the routine drug baskets at regular intervals throughout the day. But the telephone remained unbelievably quiet.

At the close of the day, the pharmacy staff sat down to evaluate the situation. How orderly the day had been! How quickly the orders had been handled when telephone interruptions had been at a minimum! The obvious conclusion: Not only had the floor staffs gotten along without the telephone calls, but they had done it without complaint.

The orderly day in the pharmacy stimulated the chief pharmacist to arrange a conference with Hazel Hinds, R.N., the hospital's director of nursing service. They discussed the relationship between the telephone, the nursing stations, the pharmacy, the patients, and efficiency, as exemplified by the previous day. How to sustain that efficiency was the question.

"For a trial run," said Miss Hinds, "let's put an embargo on all phone calls to the pharmacy before 10 a.m." It was agreed that only real emergencies would be exempt from the regulation. The plan was presented to the head nurses' meeting the next day, and was passed with only one dissenting vote.

The following day, the plan went into effect, and only three telephone calls came in the pharmacy before 10 a.m. One was from surgery, the second from a medical intern, and the third from a nurse who needed immediate information.

The plan has since proved eminently successful. Almost overnight the pharmacy became more efficient. Minutes previously given to telephone conversations and subsequent efforts to pick up interrupted activities, were freed for completion of floor stock orders and assembling of patient medications. Moreover, the early-morning embargo on phone calls seemed to decrease unnecessary calls the rest of the day, also.

And, as had been suspected, many of the calls directed to the pharmacy had been unnecessary. One most annoying source had been floor personnel who refused to make the trip to the pharmacy "lift" unless they had been assured by telephone that a certain medication was ready for pick-up. Other unnecessary calls had concerned drugs which were due to arrive in the drug basket before medication time. Some calls had been initiated by overanxious new students on the floor.

Probably the most dramatic dividend of the plan was the return of drug baskets to the stations as much as 45 minutes earlier, because of increased pharmacy efficiency. Coupled with the faster service, however, were other, equally important benefits.

Fewer complaints were received which, of course, eliminated still more telephone calls. The time saved in servicing nursing stations could be devoted to much-needed departmental planning. From this, further dividends have already accrued through institution of more intensive stock inventory procedures and revised procurement measures.

(*Continued on next page*)

*Chief pharmacist, Good Samaritan Hospital, Portland, Ore.

prescription pad

For Removal of Cerumen

Cerumenex is a quick-acting preparation designed to provide easy, safe removal of cerumen.

The preparation contains Cerapon, 10 percent, in propylene glycol with chlorbutanol, 0.5 percent.

Cerumenex is supplied by The Purdue Frederick Co. in 15 cc. dropper bottles.

For Acne Therapy

Zinc sulfate and sulfurated potash are combined with inert stabilizing agents in Lotioblanc, marketed by Arnar-Stone Laboratories, Inc.

It is applied topically for treatment of acne, seborrheic dermatitis, and related conditions, and is available in 4-oz. bottles.

Antidiarrheal Therapy

Polymagma Plain is indicated for symptomatic treatment of nonspecific diarrhea. Wyeth Laboratories is the manufacturer.

Each 30 cc. contains 3 Gm. Claysorb, activated attapulgite, and 270 mg. pectin, in a special alumina gel.

Administered orally in suspension form, Polymagma Plain is marketed in bottles of 12 fl. oz. each.

Appetite—Growth Stimulant

Formatone has been announced by Ives-Cameron Co. for stimulation of appetite, promotion of growth.

Each teaspoonful of Formatone includes 12.5 mg. thiamine hydrochloride (vitamin B_1), 10 mct. cyanocobalamin (vitamin B_{12}), and 1 mg. pyridoxine hydrochloride (vitamin B_6), in a sherry wine base (15 percent alcohol) containing sorbitol, vitamin absorption enhancement agent.

Formatone is supplied in bottles of 15 fluid ounces.

Control of Ulcer Pain

Promyl tablets, for control of ulcer pain, have been released by Crookes-Barnes Laboratories.

Each tablet contains 5 mg. pipenzolate methylbromide, 300 mg. aluminum magnesium hydroxycarbonate, and 200 mg. aluminum proteinate.

Promyl is supplied in scored, yellow tablets in bottles of 100.

Adrenocortical Therapy

Prednis-C.V.P., manufactured by Arlington-Funk Laboratories, is for rheumatoid arthritis, bronchial asthma, and other prednisolone-amenable conditions.

Each capsule provides 4 mg. prednisolone, 100 mg. water-soluble, biologically active citrus bioflavonoid complex, 100 mg. ascorbic acid, 100 mg. aluminum hydroxide, and 100 mg. magnesium oxide.

Capsules are supplied in bottles of 30, 100, and 500.

Analeptic Agent

Megimide, marketed by Abbott Laboratories, acts on the central nervous system to counteract barbiturate depression, or to restore protective reflexes following administration of intravenous barbiturates.

A synthetic compound in solution, Megimide is administered intravenously in intermittent doses. It can be used to counteract barbiturate anesthesia only, and is not recommended for use with other anesthetic agents.

The drug is supplied in sterile 10-cc. ampuls, each containing 50 mg. Megimide dissolved in 10 cc. of isotonic saline.

PROTECTION*

*Ident-A-Band is the *one* system that provides *sealed-on* protection—the system that *rivet-seals* all identifying data inside. And only Ident-A-Band gives this really permanent *sealed-on* and *sealed-in* protection... at a cost so reasonable that every hospital can easily afford it.

Ident-A-Band®

prevents mixups!

Free Ident-A-Band Samples – Complete information without obligation. Write –

Franklin C. Hollister Company
833 N. Orleans St., Chicago 10, Ill.

PHONE JANGLE continued

However, it was found that the "no phone" plan required continuing effort. Thus, two weeks after the program began, the chief pharmacist sent a note to the director of nursing service, commending the co-operation of the nurses. She paraphrased the letter and distributed it to all nursing stations, thus keeping the policy before all concerned, and, at the same time, bringing a word of encouragement to co-operative personnel.

Alert to the need for continuing work on the project, the pharmacists have been quick to question embargo violators. The offending caller is advised of the ruling courteously. It usually happens that the person is new, has been away, or for some other reason, is uninformed.

In addition to benefitting the pharmacy, the plan has salutary effects for the nursing service, too. It takes two to make a phone conversation, and a nurse's time is as valuable as a pharmacist's. By avoiding unnecessary disruption of the duty schedule, nursing time can be made more productive.

Hospital pharmacists who have a telephone or intercom problem in the mornings, when doctors' orders are stacked high and patient requirements are many, may find an answer in this plan, regardless of whether drugs are picked up at the pharmacy or are delivered via messenger, conveyor, or elevator.

The plan can help both pharmacy and nursing service provide more orderly service to the patient, and faster and more efficient dispensing and receipt of drugs within the hospital. And it can mean a time bonus for both departments.

The chances are that both services will bank big profits.

clinical notes

Blood Matching a Factor In Corneal Transplants

Matching the blood of persons donating and receiving cornea transplants may prevent one type of transplant failure, according to three Ohio State University researchers.

In the September issue of *Archives of Ophthalmology*, William H. Havaner, M.D., George T. Stine, M.D., and Larry L. Weiss, have suggested that eye surgeons keep records of the blood types of corneal recipients and donors and submit them to the national committe on eye banks for study. These records could show the statistical relationship between transplant failures and blood type incompatibility.

Tissue intolerance has been suggested as the cause of the opacity which sometimes develops following transplants. To test their theory that this intolerance was some type of blood incompatibility, the researchers conducted a preliminary study of 21 corneal transplants in which the blood types of donor and recipient were known. They found that of 17 patients with compatible blood types, the corneas of 14 remained clear. In the four patients with incompatible blood types, all the corneas became opaque.

The doctors point out that while the study is small, the results are significant enough to warrant gathering further data.

Isoniazid Found Effective In Major TB Complications

The U.S. Public Health Service recommends that infants under one year who are tuberculin-positive and children between one and four who have x-ray evidence of active primary tuberculosis should be treated with daily doses of isoniazid, according to Edward T. Blomquist, M.D., chief of the USPHS tuberculosis program.

The recommendation was based on a study in 33 pediatric clinics and involving more than 2,700 children with asymptomatic tuberculosis. It was found that daily administration of isoniazid for 12 months prevented at least 80 percent of the major complications occurring in childhood tuberculosis.

New Blood Test Developed For Lupus Erythematosus

A new blood test may help doctors diagnose lupus erythematosus in time for effective treatment, the Veterans Administration has reported.

The test uses a blue dye, 2-6 dichlorophenolendophenol, which changes color when mixed with a blood sample from a person who has the disease. The test often shows the presence of the disease even before definite clinical signs and other laboratory tests, the VA states.

The method was devised by C. David Cooper, M.D., George Washington University, and Thomas McPherson Brown, M.D., William R. Felts, M.D., and Ruth H. Wichelhausen, M.D., of the university and the Washington, D.C., VA Hospital.

The NEW DUAL PURPOSE

3" x 9" STRIP

Shorter length ends waste on small area wounds. New Z-fold insures perfect graft takes. Guaranteed sterile at time of use.

6th SIZE of VASELINE® PETROLATUM GAUZE

3" x 3" PAD

Three-ply, fine-mesh gauze, lightly impregnated — for use in physician's office, industrial medical department, first aid.

Now supplied in: 1/2" x 72" · 1" x 36" · 3" x 3"/3" x 9" · 3" x 18" · 3" x 36" · 6" x 36"

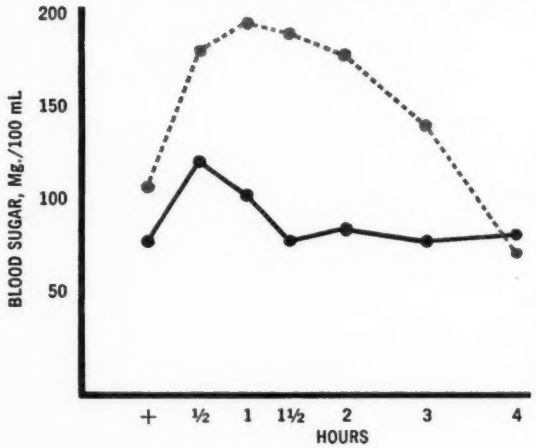
Sole Maker:
CHESEBROUGH-POND'S INC.
Professional Products Division
New York 17, N. Y.

VASELINE *is a registered trademark of Chesebrough-Pond's Inc.*

AN AMES CLINIQUICK

CLINICAL BRIEFS FOR MODERN PRACTICE

HYPERGLYCEMIC EFFECT OF CORTICOSTEROIDS[2]



Mean blood glucose levels in *normal subjects* during glucose tolerance tests.

_____before administration of corticosteroids

----------after administration of corticosteroids

what preparation of the patient is necessary prior to a glucose tolerance test?

For at least three days before testing, the patient should be on a daily diet of at least 300 Gm. of carbohydrate, 80 Gm. of protein, and calories sufficient for maintenance.[1] Adrenal steroids decrease glucose tolerance[2] and should be withheld prior to the test.

Sources—1. Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, p. 156. 2. Hennes, A. R.; Wajchenberg, B. L.; Fajans, S. S., and Conn, J. W.: Metabolism 6:339, 1957.

rapid, reliable follow-up tests

standardized tablet tests... ...“dip-and-read” Reagent Strips

CLINITEST® BRAND ...for glycosuria... CLINISTIX® BRAND

ALBUTEST® BRAND ...for proteinuria... ALBUSTIX® BRAND

ACETEST® BRAND ...for ketonuria.... KETOSTIX® BRAND

AMES COMPANY, INC • ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

46058

New Method of Treating Pooled Human Plasma Reported at ACS Meeting

• *The talk abstracted here was presented during the 44th annual clinical congress of the American College of Surgeons, held in Chicago in October.*

The addition of 1:5000 formaldehyde and 5 percent dextrose to pooled citrated human plasma enables the plasma to withstand heating at 60°C. for 10 hours with minimal alterations. The heat process inactivates the virus causing homologous serum jaundice.

Thus, a bacterially sterile plasma preparation is provided despite willful bacterial contamination. The addition of the formaldehyde prevents the plasma from coagulating under the heat.

Formaldehyde at 1:5000 is virucidal for many agents, but we have no knowledge of such action with reference to the virus of homologous serum jaundice.

At the 1:5000 concentration formaldehyde is effectively bactericidal for non-sporing bacteria; thus it offers a safeguard in the handling of plasma prior to heating.

In another experiment, the tolerance of dogs for canine plasma, subjected to heat and formaldehyde, did not appear to be affected by changes in the plasma's electrophoretic patterns, optical density, and viscosity. Although it is possible that these changes may make homologous plasma antigenic, this has not yet been demonstrated.

Experiments have also proved that this treatment of plasma does not interfere with its nutritional value, increase reaction rates, or produce detectable toxic effects in dogs transfused daily with canine plasma similarly treated.

Although an earlier experiment of ours showed that liquid pooled plasma is safe after six months' storage at room temperature, 32°C., this method is believed to be impractical for large-scale use.

First, the temperature of 32°C. is highly suitable for bacterial proliferation if contamination has occurred. Therefore, all plasma must be bacteriologically sterile prior to storage.

While this can be easily accomplished by blood banks, most pharmaceutical manufacturers have not had experience with asepsis in the manufacture of sterile biologicals, and therefore, are reluctant to consider this method of plasma production.

Second, the six-month storage precludes the rapid accumulation of a supply of plasma in a time of emergency. — *Abdul Al-Shamma, M.D., William W. Pfaff, M.D., Edward A. Stemmer, M.D.,* and *J. Garrott Allen, M.D.,* all of the William H. Danforth Laboratory for Research in Surgery, Department of Surgery, University of Chicago School of Medicine.

Hospital Lab Needs Listed By Accreditation Board

Radiology Requirements Also Designated by Joint Commission

Basic laboratory and radiological services required for good hospital service are detailed in Bulletin No. 15 of the Joint Commission on Accreditation of Hospitals.

Although the extent and complexity of the facilities depends upon the needs of the patients, the commission has set forth minimum requirements and recommendations.

Good personnel and supervision are important, the commission stresses, adding that ideally every hospital should have registered technicians as required for the work performed, and should also have its own pathologist. The alternative suggestion is a pathologist on a regular part-time or consulting basis. When possible, the pathologist should be a member of the hospital's tissue committee.

Quality as well as number of technicians employed, in relation to services performed, is noted as important in providing good laboratory service.

Other factors are adequacy, speed, and completeness of laboratory service. Among the specifications are signed reports in the patient's record, duplicate copies filed in the laboratory, a tissue file and index, and physician-signed orders for laboratory work.

For hospital accreditation, the commission requires a urinalysis and hemoglobin test or hematocrit determination for all patients admitted.

It is desirable for the hospital to have a blood bank, established and supervised under strict regulations. Where this is not possible, there should be at least proper blood storage facilities under adequate control and supervision, the bulletin says. These storage facilities should have an alarm system, warning of loss of electric power or faulty temperatures.

Autopsies are an important factor and every good hospital should have its own morgue, if possible. The commission recommends an autopsy rate of at least 20 percent for nonteaching hospitals and at least 25 percent for teaching hospitals.

Attention is called to the necessity of checking the calibration of special laboratory equipment regularly. Faulty thermometers and

(Continued on next page)

inaccurate colorimeters have been reported in several hospitals visited.

In discussing the x-ray department, the bulletin points out that diagnostic x-ray facilities in the hospital or in an adjacent clinic are required for the hospital's accreditation.

The need for qualified personnel is stressed. Every hospital should have a qualified radiologist, either full-time or part-time on a consulting basis, both to supervise the department and to interpret films which require specialized knowledge for accurate reading.

At least one technician registered by the American Registry of X-Ray Technicians is necessary in the commission's opinion.

Signed reports of x-ray film interpretations in patients' files, duplicates in the x-ray department, and an index of x-ray reports according to radiological diagnosis, are among department specifications.

Others are freedom from fire and explosion hazards, shock-proof equipment, usual safety measures, and periodic (at least twice a year) blood counts and exposure tests for personnel.

Special recommendations from the American Medical Association, the American College of Radiology, and the AHA concerning fluoroscopes, radium, and radioisotopes have been approved by the Joint Commission. These include:

Fluoroscopes and radiographs: Use limited to persons designated as qualified by the radiologist, roentgenologist, or an appropriate committee; inclusion of a special data sheet, specifying date, site, roentgens per minute, exposure time, and operator, for fluoroscopic examinations, in all hospital and clinical charts; timers on fluoroscopes.

Use of radium element, its disintegration products, and radioactive isotopes: Supervision of a certified physician; user designated as qualified by the radiologist or appropriate committee; institution of regulations as to application and removal; availability of services of a physicist qualified in radiation physics for a department having a supply of the materials.

Tubeless Gastric Analysis Found To Be Accurate Test

Results in a recent study indicate that the tubeless technic of gastric analysis is reliable even in the presence of heart, liver, or kidney disease.

Theodore Rodman, M.D., Arnold Gutman, M.D., and Ralph M. Myerson, M.D., VA Hospital, Philadelphia, tested the technic, which involves ingestion of an organic dye and a subsequent color test of the urine to detect the presence or absence of acid.

During the study, reported in the May 10 issue of the *Journal of the American Medical Association*, 114 patients were given the tubeless test, followed by a standard gastric analysis.

There were seven false reactions from among 26 patients with kidney disease, and one false reaction among 39 patients with liver disease.

OZIUM®

the Glycol-ized AIR FRESHENER

SPRAYS AWAY OFFENSIVE ODORS INSTANTLY!

Quickly dispels odors resulting from

- THIRD DEGREE BURNS
- BEDPANS
- CANCER
- COLOSTOMIES
- ETHER
- GANGRENE
- PAINT
- PATHOLOGY DEPT.
- LAUNDRY & KITCHEN
- RADIOLOGY DEPT.

Also rids the air of smoke and reduces air-borne bacteria.

No. 500 "Personal Size" OZIUM Dispenser conveniently fits in nurse's pocket or in patient's bedside table drawer.

For larger space areas, No. 3000 OZIUM Dispenser assures 3,000 or more "King Size" Individual *Measured* Sprays.

NEW *No. 500 Patented Meter Valve Assures 500 Individual* Measured *Sprays.*

Call your hospital supply dealer for a demonstration

Manufactured by **WOODLETS INC.**
2048 Niagara Street, Buffalo 7, N.Y.

Sold in Canada by
G. H. WOOD & COMPANY, LTD., TORONTO
Branches Across Canada

The Mothercraft Concept In Maternal Care

By Kate H. Miles*

• In a pleasant residential section of Toronto stands a beautiful building, still bearing all the outward signs of a home. On one of its gateposts is a brass plate inscribed "Mothercraft Centre." A wall and fence give the building privacy, but passersby can catch glimpses of a circular drive, shrubbery, a large piece of statuary, and the facade and porte-cochere of a formal residence.

This is the somewhat unorthodox appearance of a general hospital which is recognized by the Ontario Department of Health, but which does not receive cases of sickness or disease. And perhaps its unorthodox appearance is in keeping with its philosophy. For this is the Mothercraft Hospital.

The former owner of the property had learned of Mothercraft in London and had met its founder, Dr. Frederick Truby King of New Zealand. Early in the Forties, she made private arrangements with the president of the Canadian Mothercraft Society to transfer the estate to the organization at a fraction of its value, and to move in the new occupants.

What is the purpose of this strange type of hospital? Briefly, health—for the mother and her new baby. Dr. King believed that when the wife and mother understands her job and has the fundamentals of health within her grasp, she can give her baby the best possible start and can make her home a place of happiness and an important part of national life. He made the concept work in his native country over fifty years ago; it still works there, and in other countries as well.

It was in 1907 that Dr. King returned from Edinburgh to New Zealand at the government's invitation to organize an adequate hospital and nursing system. Special attention was paid to maternal and child care, in an effort to reduce the appalling infant mortality. So sound were the practices Dr. King set up that in one year New Zealand's infant death rate was reduced by one-half.

Under the system, maternal and child care were considered as one division rather than two. Special hospitals were established to which mothers could go for a transition period after leaving the maternity hospital. In addition, small centers were made available to mothers in remote sections. In later years, mobile clinics became the extended service.

*Canadian Mothercraft Society, Toronto, Ont., Canada.

To make his teaching available to all women, everywhere, Dr. King prepared a 3-month postgraduate course for registered nurses, and a 1-year course for young girls, which was intended as a training in motherhood. So valuable were these young nurses with their specialized training that in New Zealand as well as in other countries where the work was later established, these nurses have found favor both with mothers and also with the majority of doctors. The training they receive is both a profession, while they work, and a preparation for their own motherhood.

Naturally the sharp reduction in infant deaths in New Zealand brought inquiries from all parts of the world, and eventually, Mothercraft organizations were established in all the countries of the Commonwealth. Always, these were voluntary organizations, recognized by the government. Mothercraft is the name generally used today, although in New Zealand, the formal designation has always been The Royal Society for the Health of Women and Children. It is estimated that today, 80 percent of the babies born in New Zealand each year are cared for under this system.

The Canadian Mothercraft Society was founded in 1933 and was patterned on the New Zealand organization. The aims and objectives of the Canadian Mothercraft Society are these:

"1. To uphold the sacredness of the body and the duty of health; to inculcate a lofty view of the responsibilities of maternity and the duty of every mother to fit herself for the perfect fulfillment of the natural calls of motherhood, both before and after childbirth, and especially to advocate and promote the breast-feeding of infants.

"2. To acquire accurate information and knowledge of matters affecting the health of women and children, and to disseminate such knowledge through the agency of its members, nurses and others by means of the natural handing-on from one recipient or beneficiary to another and the use of such agencies as periodical meetings at members' houses or elsewhere, demonstrations, lectures, correspondence, newspaper articles, pamphlets, books, etc.

"3. To train specially, and to employ qualified nurses, to be called Mothercraft nurses, whose duty it will be to give sound, reliable instruction, advice

(Continued on next page)

and assistance to any member of the community desiring such services, on matters affecting the health and well-being of women, especially during pregnancy and while nursing infants, and on matters affecting the health and well-being of their children, and also to endeavor to educate and help parents and others in a practical way in domestic hygiene in general, all these things being done with a view to conserving the health and strength of the rising generation and rendering both mother and offspring hardy, healthy and resistive to disease.

"4. To co-operate with any present or future organizations working for any of the foregoing or cognate objects."

The field of Mothercraft begins prenatally and goes on until the child reaches school age. At the Mothercraft hospital, classes, in eight- or nine-week courses, are held weekly for pregnant women, who come with their doctors' consent. Preparation for the Grantly Dick Read method of conscious birth is given by nurses trained at the Maternity Center, New York.

After the birth of the baby in the obstetrical section of one of the regular hospitals, some of the mothers who have had this prenatal preparation carry on by going for a short period to the Mothercraft Hospital, or by engaging a well baby nurse, trained by Mothercraft to carry on part of the program at home. There are district clinics, also, and headquarters offices where postgraduate nurses are available for consultation and advice.

With few alterations, the handsome residence acquired in 1942 has been adapted to the purposes of a Mothercraft hospital. There are two large wards for older children on the ground floor; one of these opens on to a porch and terrace overlooking acres of lawns and gardens. Upstairs are beds for nine mothers with adjacent nurseries for their babies; thus, the babies are always available for periods of mothering, for practice in bathing, and for feeding. The mothers' meals are served in a handsome sitting room, where they may also relax. With few exceptions this period at the hospital provides a transition, especially for the mother of a first child. The mother obtains a relaxed nervous system, enjoyment of surroundings, good food, and valuable information.

From his research on the care of the child, itself, Dr. King came to the conclusion that every baby, whether ill or well, needs twelve essentials. These essentials are: air, water, food (the best food being the mother's milk), clothing, bathing, muscular exercise and sensory stimulation, warmth, regularity of all habits, cleanliness, mothering, management, and rest and sleep.

Each essential was described by Dr. King in his writings. Recently, to mark the fiftieth anniversary of the work in New Zealand, the nursing body prepared a book, *From the Pen of F. Truby King*, which explains his findings and his beliefs.

Outstanding in his concepts is the great responsibility he gave his nurses. They were taught to plan diets for babies—a controversial point at that time—and were taught how to render, by caloric estimation, the milk of any animal—cow, camel, or water buffalo—to the percentage composition of human milk.

Dr. King believed in breast feeding in almost every instance, but, for the exception, he prepared Karitane products, which today are available around the world. They are made by a non-profit factory, and have come into Canada duty-free since the Society was organized.

UL AND CSA

Every Armstrong Baby Incubator carries on the name plate the Underwriters' Laboratories (UL) seal of approval and the Canadian Standards Association (CSA) seal of approval. The Armstrong X-4 was the ***first*** Baby Incubator ever to be tested and approved by Underwriters' Laboratories. All Armstrong Baby Incubators are still subject to the Underwriters' Laboratories re-examination service.

Write or phone us Collect for free bulletins.

THE GORDON ARMSTRONG CO., INC.

504 Bulkley Building

Cleveland 15, Ohio • CHerry 1-8345

Maintenance of Electrolyte Balance Imperative in Infants

Nurse Has Vital Role As Adjunct in Fluid Therapy

The following abstract is taken from a lecture at the seminar on the care of premature infants held recently in Miami, Fla.

The roles of the various electrolytes are the same in infants as in adults.

Sodium maintains a normal balance of water between various compartments, both intracellular and extracellular; potassium and calcium maintain neuromuscular function, with potassium disturbances producing changes in muscle and nerve function, particularly in the cardiac muscle; chlorides and bicarbonates, maintained in normal concentrations, enhance acid-

base balance; organic acids are concerned with the products of metabolism, primarily fat, and are not clinically a problem. The role of magnesium is not well appreciated. Serum protein is active in maintaining the volume of material in circulation.

Dehydration, whether from disturbances of the gastrointestinal tract causing excessive loss of fluids, from inadequate fluid intake, or from insensible water losses, will cause a disturbance in electrolyte balance.

To maintain electrolyte balance, infants must have water and chemicals administered parenterally. There are marked differences between infants and adults in water needs and total body weights. For example, a seven-kilogram infant requires 700 cc. of water for normal metabolism; a 70-kilogram man, under the same circumstances, needs 2,500 cc. In the adult, 70 percent of the total body weight is fluid; in the infant it is 80 percent.

Water losses are increased significantly in the infant by hyperventilation and insensible loss can be cut down by keeping the infant in an environment of 100 percent relative humidity. Fluid and electrolyte therapy in the premature must be most precise because an infant's kidneys have limited ability to eliminate. The adjustment mechanism of urine concentration in prematures is limited. Intake must balance output.

Prematures have low sodium requirements and tolerate excesses very poorly. If they retain sodium, they must also retain water.

Acidosis and alkalosis result from a disturbance of the pH of the body, which is related to the function of bicarbonates. The limits are very narrow and the concentration will fluctuate depending on the pH of the individual. Sodium lactate, which is more stable and more easily stored than sodium bicarbonate, is less valuable in the treatment of prematures or other infants because of their poor metabolism of lactate.

Principles of therapy are built around supplying water at the level required for a given 24-hour period; providing prepared water to make up electrolyte deficits; and estimating the amount of water needed to correct disturbed states. Dryness of the skin and mucous membranes usually indicates about a five percent dehydration; gross dehydration, as from diarrhea, when the eyes and fontanelles are shrunken, indicates a loss of between 15 and 20 percent of total body weight.

Laboratory-determined values of concentrations of potassium and sodium in serum are essential for good replacement therapy.

The nurse is a valuable adjunct in fluid therapy. Careful control of the rate of administration of fluids is imperative—infants are easily drowned. Accurate recording of what is administered is imperative. Observation of the infant for signs of excess fluid is imperative. Either intravenous drip or subcutaneous clysis is satisfactory, although the rate of absorption and flow is more easily controlled with the intravenous technic. Subcutaneous clysis, however, is satisfactory and apparently not uncomfortable for infants.—*W. W. Cleveland, M.D.*, assistant professor of pediatrics.

Premature Birth May Cause Reading Disorders

Premature births and complications during pregnancy may be factors in causing reading disorders among children.

This theory is advanced by Ali A. Kawi, M.D., and Benjamin Pasamanick, M.D., in a study reported in *The Journal of the A.M.A.*

The authors reason that since the brain plays a major role in the ability to read, brain damage occurring during pregnancy could contribute to reading disorders in children in the same way such damage causes cerebral palsy or fetal death.

In a study comparing 205 boys, 10 to 14 years of age, known to have reading disorders, with a similar group of boys with normal reading behavior, it was found that 16.6 percent of the children with disorders had been exposed to two or more maternal complications as compared to 1.5 percent in the control group.

Maternal complications which appear to be associated frequently with reading disorders, according to the doctors, are "pre-eclampsia, hypertensive disease, and bleeding during pregnancy." The three conditions, they add, tend to produce an oxygen deficiency.

The study also showed that 11.5 percent of the children with reading disorders had been born prematurely, while only 4.6 percent of the control group were premature births. These figures may have some connection with the fact that premature infants are more susceptible to oxygen deficiencies.

FALCON LIQUID-TITE
disposable

sterile
LIQUID CONTAINER

This polyethylene plastic bag with wide mouth and screw cap for collection of body fluids and urine offers new economy and efficiency for hospital, laboratory and outpatient use.

Inexpensive Liquid-Tite is used once and discarded, saving costly washing, sterilizing and handling of conventional containers. Saves on storage space too.

Send for new free catalog today.

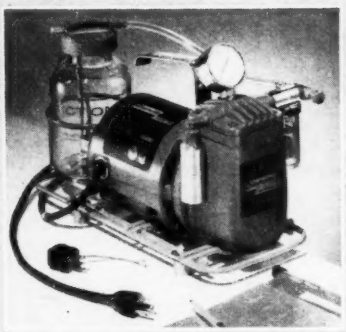
FALCON PLASTICS

6018 WEST WASHINGTON BOULEVARD, CULVER CITY, CALIFORNIA

Trouble-free Air-Shields Dia-Pump® . . .
with MICRO-FILTER for pathogen-free operation!

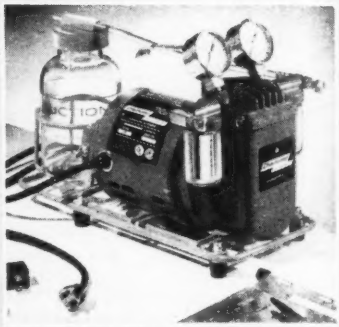
Now, with the exclusive New MICRO-FILTER, the AIR-SHIELDS DIA-PUMP® provides a safe source of pathogen-free compressed air to operate the ISOLETTE® ROCKER, the CROUPETTE®, the VAPOJETTE®, or any atomizing device. Greater safety is insured with the DIA-PUMP ASPIRATOR because the new MICRO-FILTER removes pathogens from the air before it leaves the pump.

3 LOW-COST MODELS:



DIA-PUMP ASPIRATOR (Model EFA), an ideal suction pump, provides vacuums to 22" Hg. with **MICRO-FILTER** to prevent pathogenic bacteria from escaping to room air.

DIA-PUMP COMPRESSOR (Model EFC), for continuous, heavy-duty operation, provides **MICRO-FILTERED** air at controlled, positive pressure to 30 pounds per square inch.

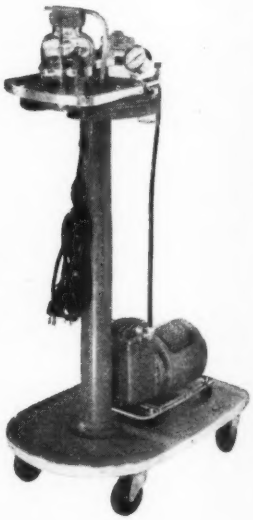


Dual purpose DIA-PUMP COMPRESSOR-ASPIRATOR (Model EF) with **MICRO-FILTER** provides regulated suction to 22" Hg. and controlled positive pressure to 30 pounds per square inch.

Because of its simple, rugged design and tough Neoprene-Nylon diaphragm, the AIR-SHIELDS DIA-PUMP runs indefinitely and cannot "freeze," rust, or jam, from condensed or even aspirated moisture. The DIA-PUMP has been test-run continuously, day and night, for an entire year, without failure of any part, and all three models are *unconditionally guaranteed for one year!*

Each **AIR-SHIELDS DIA-PUMP** is supplied with:

- 1/6-HP motor built for continuous operation.
- Large easy-to-read gauges.
- 1000-cc. suction bottle with each ASPIRATOR.
- Needle valve controls.
- Plastic-coated frame with rubber feet to stop vibration.
- MICRO-FILTER to protect patient, and operator.



MOBILE BEDSIDE DIA-PUMP Compressor-Aspirator with MICRO-FILTER, rolls quietly and smoothly on rubber casters to any bed in the hospital. When in use, protrudes less than a foot from the bed.

The Dia-Pump® mobile or portable

aspirator, compressor and compressor-aspirator by **AIR-SHIELDS, INC.**

Hatboro, Pa., OSborne 5-5200*

*Representatives throughout the country. For more information or orders, write or call us collect, from any point in the U.S.A.
In Canada: Air-Shields (Canada), Ltd., 8 Ripley Ave., Toronto 3, Ont., Roger 6-5444.

Pediatrics

Closed-Circuit TV System Monitors Pediatric Patients

• The TV set at the nurses' station was making its rounds of the pediatrics department. It paused briefly to picture Billy (asleep), note Johnny (reading), and look in on Ann (daydreaming).

Then Mary came into view, one leg over her crib rail, eyes focused on a pile of crayon books on a nearby chair. The nurse pressed down the "hold" lever keyed to Mary's room on the TV board, and asked, conversationally, "Where are you going, Mary?" She received, along with an unabashed grin, the blanket remark considered *de rigueur* among youngsters: "Nowhere." It turned out, however, that where she was going was back to her crib; it was equally evident that that was not her original plan.

The closed-circuit TV monitoring system in the pediatrics department at St. Joseph Mercy Hospital, Mason City, Ia., was installed a year ago, and was the first of its kind to be put into operation in the U. S. Since then, its activities, and responsibilities, have been extended to nearly every phase of pediatric care at Mercy.

Originally a small department in the old portion of the hospital, pediatrics was incorporated into the first new wing when renovation of the hospital started in 1941. Architect Robert Trevs, of Ann Arbor, Mich., added such innovations as acoustic ceilings and piped-in oxygen for the new children's floor. He also campaigned vigorously for the installation of the closed-circuit TV system, which had impressed him at several architectural conventions. A demonstration unit was set up at the opening ceremonies of the wing, using doctors' children as patients.

It was not until 1957, however, that the TV system became a regular member of the staff, and the original magnetism it held for youngsters has proved one of its most potent features.

Unlike adults, who might consider being exposed to the camera's eye at announced intervals the first step toward a "Big Brother" philosophy, children are intrigued by the monitoring. For them, apparently, it combines the pleasant uncertainty of "when," and the instinct for mischievous give-and-take, with the inevitable surrender to the voice of authority.

(Continued on next page)

Above: Sister Francelyn, supervisor of the pediatrics department, St. Joseph Mercy Hospital, Mason City, Iowa, does preliminary rounds with change nurse, Mrs. Stan McClintock, without leaving the nurse's station. The closed-circuit TV system flashes from patient to patient for continuing surveillance. Below: Lola Hilleland, student nurse, receives instructions via the receiving unit. Nurses may be contacted at any point in their rounds with a change in orders, or a request to interrupt the routine for emergency reasons.

In the incident just described, without the help of the TV monitor the nurse might not know Mary was well on her way to climbing (or falling) out of her crib. Alerted, the nurse can almost always handle such a situation without interrupting her work.

The little fellow above, suffering mainly from fear and loneliness, will receive a generous dose of T.L.C. when his picture is picked up on the screen. The young lady below will be given firm, but friendly, advice to return to her crib and let the nurse's aide give her the crayon books she has her eyes on.

The original in-person comradeship established between the nurse and a new patient carries over into the medium of TV, and is further fortified by the fact that the patient, as well as the nurse, has a voice in the proceedings. Any resentment the child might generate from being "talked at" by the nurse, or other personnel, is dissipated by his ability to "talk back" on the 2-way intercom. This talking out of a situation leaves all participants satisfied.

To establish this rapport as speedily and firmly as possible, youngsters are oriented to the TV system upon admission, if their condition permits. If not, when they become ambulatory they are brought out to see and talk to their fellow patients on TV.

The secret desire to exploit their thespian abilities when "on camera" brings out the ham in small patients, but it also brings out their trust and co-operation, and gives them a feeling of security.

A similar sense of security is found, and is especially valued, by anxious parents whose children are in isolation, in need of sustained quiet, in critical condition, or emotionally disturbed. Though the parents may not be allowed to enter the hospital room or ward, they can see their youngsters, and even talk with them, if advisable.

A larger measure of professional security is afforded the nurses. For instance, maintaining a continuing check on the content level of the bottle when an intravenous is being given, is a simple matter. Respiration can be recorded without disturbing the patient. One little boy, suffering from bronchial asthma, recently had his respiration checked every two hours for three days by means of the TV amplifier.

Monitoring, when desired, can be limited to the critically ill. When the majority of patients are well on the way to recovery, or ambulatory, and only three beds are occupied by critical cases, for instance, the TV can be put on this limited circuit for continuous surveillance.

Normally, it is set to rotate from patient to patient, and room to room, at a rate of from one to 10 seconds, but it can be stopped and held at any desired location for any period of time by depressing the hold lever for that place. Each of the 17 rooms in pediatrics has a camera, and there are two each in the ward and the nursery.

The doctor's role in the department is both simplified and enhanced by the closed circuit. A quick rotation gives him the over-all picture of the department; use of the hold levers gives him a period of natural, preliminary observation before going to a patient's bedside.

Planned teaching sessions are carried on with the help of the TV circuit. Doctors making their examinations comment on the case for the benefit of students and nurses gathered around the viewing screen.

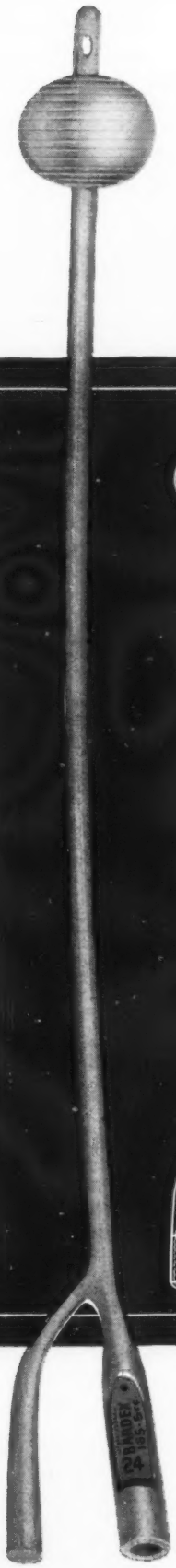
Incidental and informative material is picked up by both teachers and students in informal viewing. The charge nurse or supervisor, working at the station, can

(Continued on page 94)

these rigid specifications are

BASIC to BARDEX

for *perfected* performance



TIP Not too short, not too long. Just right to ease insertion, not so long as to irritate bladder.

EYE Properly placed and sized in strong, reinforced tip. Design that assures entirely proper drainage.

RIBS To assure even distention of balloon—extra reinforcing rubber that also strengthens balloon. Tip held in proper position, too.

SHAFT Smooth, round, with large lumen. Still another factor that means easy insertion, maximum drainage, and a minimum of patient discomfort.

PLUG Easily punctured, self-sealing and always secure. Of specially compounded crepe latex, with long ridged side-walls, and cemented in inflation tube.

SIZE Permanently shown by color patch. Identity not lost in autoclaving.

There is a difference . . . and just such "basics" as these tell you why "the standard of excellence" has long been BARDEX.

Of vital importance to hospital and patient is your specification of BARDEX, for dependable catheter performance.

BARDEX® FOLEY CATHETERS

More widely used throughout the world . . . than all other brands combined.

583 **C. R. BARD, INC.** SUMMIT, N.J.

STERILE in the durable, **easy-to-open package** that affords guaranteed protection . . .

ready for instant use without processing or autoclaving

(Continued from page 92)

observe how student nurses are approaching the patients, the sort of relationship they are establishing, how they are giving baths and nourishment, and other routine procedures. If classroom theory occasionally bogs down under the stresses of the real thing, the observer can make a note of how to guide the student further in her method of adjustment to the patient, where to review her technic to help level out rough spots.

Doctors' orders, newly entered on the charts, can be passed along via TV to the nurse at any point in her rounds, so instructions can be put into effect when she visits the patients concerned.

Probably one of the closed circuit's most vital contributions is as a preventive aid. All the photographs accompanying this article picture situations which actually arose in the hospital. The youngsters' inclination toward acrobatics returns with their improving health: the rail sitter, the explorer, the pillow tosser, and the budding pugilist whose opponent is the needle, all have their efforts recorded on the screen.

With few exceptions, their energies are channeled into more constructive activities following a firm but friendly conversation with the familiar voice which comes from the receiving unit. But if the student nurse, whose gentle hands belie a firmer impulse, gets into real difficulty, help can be dispatched and, in more serious cases—an infant entangled in its blankets and in real danger—help is immediate.

In the minds of the nurses, not the least of the alerts flashed concerns the small person whose most serious symptoms are fright and loneliness. His tearful face pictured on the screen, and his protracted sobs picked up by the sound system, call for a generous dose of tender, loving care, to be administered at once, and repeated as needed.

A cast presents a temptation to a lively boy bored with having to stay in bed. Despite instructions, written on his cast by the attending physicians, to refrain from pulling, an experiment is under way. A few words over the speaker diverts his attention.

As Sister Francelyn, supervisor of the pediatrics department, comments: "The closed-circuit TV is not a substitute for nursing care. Rather, it is an invaluable adjunct; a tool to help us channel our activities, to spot and respond to emergencies in the shortest possible time. If it is an axiom in the world of student nurses that all charge nurses and supervisors have eyes in the backs of their heads, it is an accepted fact among children that such equipment may run to three or four pairs of eyes in all adults. The TV circuit is, indeed, providing us with extra eyes and ears to increase our effectiveness in our active pediatrics department."

As soon as this baby was seen tangled in its blankets, student nurse Mary Gorbel was dispatched to the nursery. Student nurse Joan Machin, below, managed to get this rebellious patient to co-operate, but if things had gotten out of hand, another nurse would have joined her.

FOOLPROOF!

Only high steam temperatures can bring out these tell-tale marks on "Scotch" Hospital Autoclave Tape No. 222

WON'T POP LOOSE, leaves no stains or gummy residue. "SCOTCH" Hospital Autoclave Tape No. 222 sticks at a touch, comes off neat and clean. And you can write on it with pen or ink.

You're always *sure* with this tape! The special inks in "SCOTCH" Hospital Autoclave Tape No. 222 can't be accidentally activated by sunlight or radiator heat or a dry air pocket in a faulty autoclave. Only correct levels of heat AND moisture can make these distinctive diagonal markings appear . . . clearly visible across the room! Wouldn't you feel safer with "SCOTCH" Brand in *your* hospital?

REG. U.S. PAT. OFF.
SCOTCH BRAND **Hospital Tapes**

"SCOTCH" IS A REGISTERED TRADEMARK FOR THE PRESSURE-SENSITIVE ADHESIVE TAPES OF 3M CO., ST. PAUL 6, MINN. EXPORT: 99 PARK AVENUE, NEW YORK 16. CANADA: LONDON, ONTARIO.

MINNESOTA MINING AND MANUFACTURING COMPANY

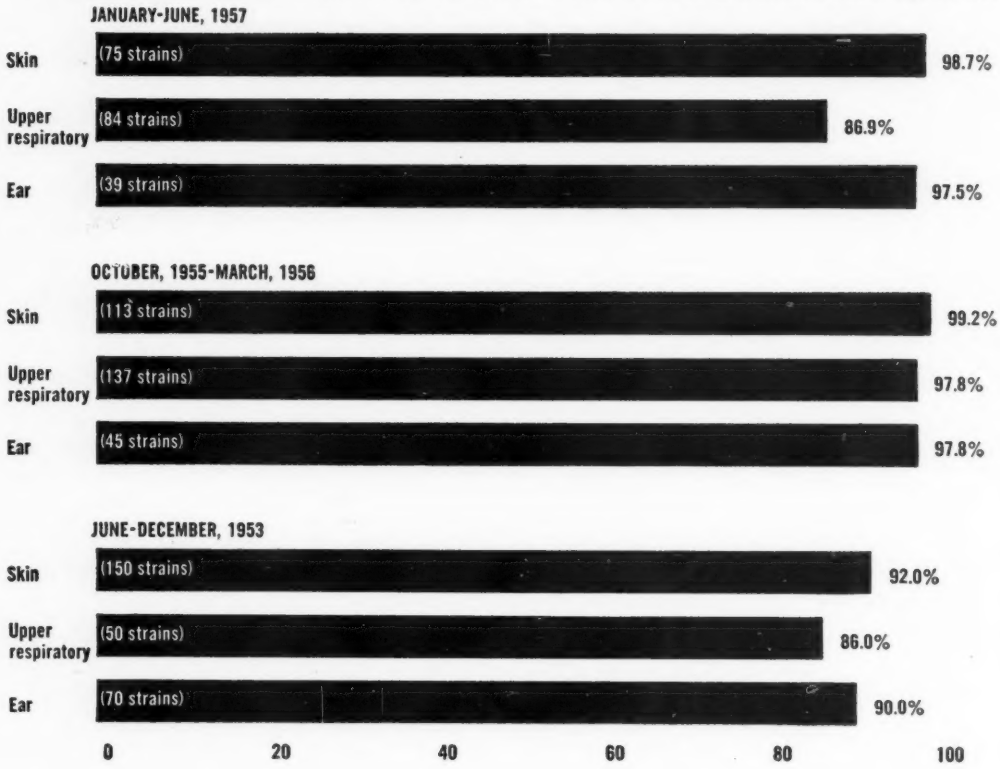
3M COMPANY

. . . WHERE RESEARCH IS THE KEY TO TOMORROW

HIGHLY EFFECTIVE AGAINST STAPHYLOCOCCI ...YEAR AFTER YEAR

CHLOROMYCETIN®

IN VITRO SENSITIVITY OF STAPHYLOCOCCI FROM THREE FOCI OF INFECTION TO CHLOROMYCETIN FROM 1953 TO 1957*



*Adapted from Royer, A., in Welch, H., & Martí-Ibañez, F: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including Kapseals® of 250 mg., bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

49339

PT Association Appoints Executive Director

Annetta Cornell Wood has been named executive director, American Physical Therapy Association. Mrs. Wood's office will be in the national headquarters of the association at 1790 Broadway, New York City.

Mrs. Wood previously worked in public relations and fund raising for the United Neighborhood Houses of New York, and prior to that, was director, Women's Division, National Fund for Medical Education.

Polio Shots Recommended For All Under Forty

Everyone under 40 who has not yet had Salk polio vaccine shots has been urged to get them as soon as possible by Surgeon General Leroy E. Burney, U.S. Public Health Service.

In a statement issued just before the peak of the polio season, he pointed out that 40 million persons under 40 have not yet had a single polio shot.

Hospital Accountants' Award Established

Robert M. Shelton, president of the American Association of Hospital Accountants, has announced the establishment of the Frederick C. Morgan Individual Achievement Award.

To be conferred annually on the hospital accountant who makes the "outstanding contribution to the hospital accounting field or attains significant individual achievement," the award is a tribute to Mr. Morgan, long-time volunteer executive secretary of AAHA.

The award is open to anyone in the hospital accounting field, and is not restricted to members of the association. Basis of judging will be the accomplishment of the nominee on local, state, and national level; personal character; civic, fraternal, and religious activities; AAHA chapter activity; state hospital association participation; educational background; and articles published and lectures and talks given.

Nominations for the first award will be closed December 31, 1958, and the medallion will be given at the annual institute of the association in July, 1959.

The association has also announced the names of eight new fellows in the group. They are:

Sister Mary Bertrand, controller, Holy Cross Hospital, Salt Lake City; *G. DeWitt Brown*, controller, Baptist Memorial Hospital, Jacksonville, Fla.; *Sister Mary Gerald*, general treasurer, Sisters of the Holy Cross, St. Mary's Convent, Notre Dame, Ind.; *V. G. Edmondson*, accounting specialist, Oklahoma Hospital Association, Tulsa.

Sister Mary Leo, business manager, Mount Carmel Mercy Hospital, Detroit; *Gerald V. Hammons*, business manager, Arkansas Baptist Hospital, Little Rock; *Ray Everett*, assistant administrator, Roper Hospital, Charleston, S. C.; and *Sister M. Electa*, business manager, Bethania Hospital, Wichita Falls, Tex.

ACHA Testimonial Dinner Honors A. J. Swanson

A testimonial dinner honored Arthur J. Swanson, chairman, Ontario Hospital Service, October 27 at the Hotel Lord Simcoe, Toronto, Ont., Canada.

The dinner was given by the Board of Regents of the American College of Hospital Administrators, in tribute to Mr. Swanson's years of distinguished service to the organization. He served for nine years as a member of the governing body, and was president in 1956.

The dinner, attended by more than a hundred fellows, members and nominees of the college from Ontario and surrounding provinces, was held during the annual meeting of the Ontario Hospital Association.

New York University Plans Rehabilitation Center

New York University, New York City, has created a center for rehabilitation services to co-ordinate and broaden the institution's various programs for the handicapped.

The center will help develop a University-wide program involving rehabilitation services, the teaching of professional rehabilitation personnel, and related research projects.

Yes, you can wax conductive floors

WITH THE ONLY CONDUCTIVE WAX THAT CARRIES THIS SEAL . . .

Huntington C-2C Conductive Wax, listed by Underwriters' as being safe for electrically conductive floors . . . makes it possible for you to simplify O.R. floor care and improve aseptic conditions. See your Huntington representative for complete details and write for free booklet, "How to Maintain Conductive Floors."

HUNTINGTON LABORATORIES
INCORPORATED
Huntington, Indiana
Philadelphia 35, Pennsylvania • Toronto 2, Ontario

HUNTINGTON
. . . where research leads to better products

WIN!

ALL EXPENSE TRIP* TO SIXTH ANNUAL CONGRESS A.O.R.N.

HOUSTON, TEXAS FEB. 9, 10, 11, 1959

(*Round-trip airline or train ticket from your home to Shamrock-Hilton, Houston, Texas; Room reservation during convention; Plus $50 cash for other expenses.)

RULES

1. Only actively employed Operating Room Nurses, other than OR Supervisors and Clinical Instructors, are eligible to win an ETHICON "Why don't they..." award.
2. Submit as many entries as you wish; however, only one award to a person. All entries will be judged on the basis of originality and practicability. Decision of the judges is final. No alternative awards will be made.
3. Judging will be done by ETHICON, INC. in conjunction with an AORN Awards Committee.
4. All entries must be made on official contest forms (or a reasonable facsimile thereof). These are obtainable from your ETHICON representative or from "Why don't they..." Contest, ETHICON, INC., Somerville, New Jersey.
5. Entries are to be sent to: "Why don't they..." Contest, ETHICON, INC., Somerville, New Jersey.
6. In case of duplicate entries, only the one bearing the earliest postmark will be considered.
7. All entries must be postmarked prior to midnight, December 15, 1958. Winners will be notified by January 1.
8. All entries become the property of ETHICON, INC.

6 WINNERS!

PLUS CASH AWARD TO EACH WINNER'S OR SUPERVISOR*

JUST COMPLETE A SENTENCE STARTING

"WHY DON'T THEY..."

Any suggestion or idea that you feel will improve OR facilities, technics, supplies or any other area of OR work can win. Suggestions may be on any aspect of the OR—not necessarily on sutures. No matter how simple you think the idea is, send it in! The simplest ideas have often been the best!

For example, someone once might have said: **"Why don't they** sterilize the instruments after each operation to lessen the dangers of contamination and infection?" Or, again: **"Why don't they** package sutures in sterile storage solution ready for immediate use in the OR?" Both of these are now accomplished facts. NOW, in 1958, can you contribute an original idea by completing this statement "Why don't they..."

IT'S EASY

YOU ARE ELIGIBLE IF you are an actively-employed operating room suture nurse other than an operating room supervisor or clinical instructor.

*YOUR SUPERVISOR WILL WIN $100 if you win one of the six awards.

You may send in as many entries as you wish, but only those postmarked prior to midnight, December 15, 1958 will be judged. Winners will be notified by January 1, 1959.

ETHICON®

To: "Why don't they..." Contest, ETHICON, INC., Somerville, New Jersey.

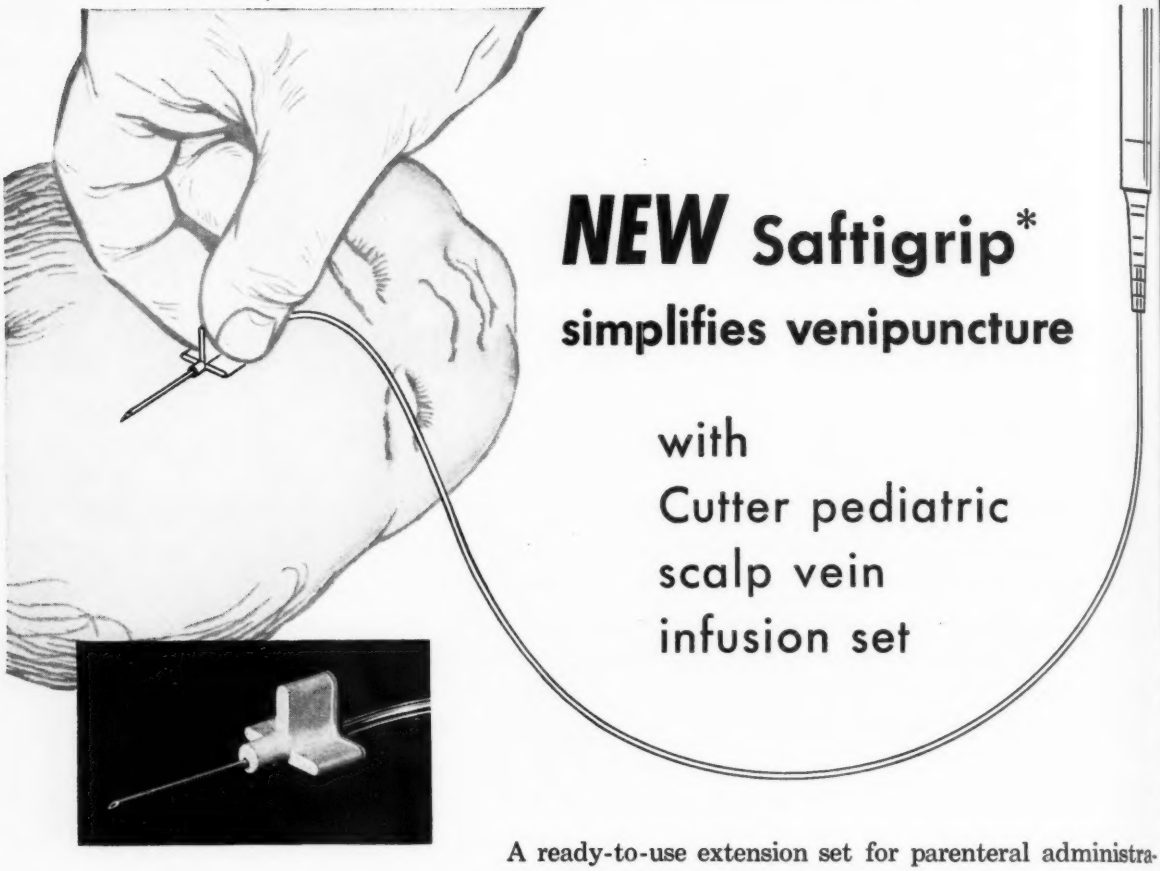
Please send me an official entry blank for the "Why don't they..." Contest.

NAME_____

ADDRESS_____

HOSPITAL_____

HT



NEW Saftigrip*

simplifies venipuncture

with
Cutter pediatric
scalp vein
infusion set

Each set consists of:

plastic female adapter for easy attachment to I.V. set;

12 inches of soft pliable tubing for easy coiling and taping to scalp;

short-beveled, sterilized 20 gauge needle in protective sheath;

finger-tip rubber grip for easier insertion into vein;

sterile and ready to use.

A ready-to-use extension set for parenteral administration of fluids into the scalp vein of infants.

Now the Cutter Pediatric Scalp Vein Infusion Set is easier to use than ever. The new rubber **Saftigrip** holds the bevel in correct position...provides finger-tip control for easy insertion...acts as an overlay to strengthen joint of needle and tubing.

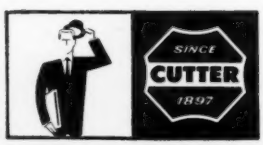
No head restraints

The flexible extension set allows easy coiling and taping to the scalp permitting normal head movement. Restraints are not necessary. Baby is more comfortable. Cut-downs are rarely required.

FOR GREATER SAFETY...GREATER SIMPLICITY
CUTTER SCALP VEIN INFUSION SET

*T.M.

ask your Cutter man
for more detailed information



CUTTER LABORATORIES Berkeley, California

HOSPITAL Topics OR

Official bulletin for the
Association of Operating Room Nurses

Sixth AORN Program is Texas—Big!

EVERYTHING is Texas-big about the program planned for you February 9-12, 1959, in Houston, Tex. It's as big as the block-long swimming pool at the Shamrock-Hilton, headquarters hotel—or the 20-million-dollar medical center across the street. See the million-idea scientific program, pages 115 to 117, and the million-dollar technical exposition preview, starting on page 120!

A Sterile, Waterproof Plastic Operative Field

By Carl W. Walter, M.D., and Richard E. Wilson, M.D.*

• Bacteria resident in the skin glands and hair follicles escape destruction during the usual preoperative skin preparation. During the course of a long operation, these bacteria multiply and are exuded to the surface in sweat and sebum as a result of manipulation and the physiologic response to surgery and anesthesia.

Surgical drapes of many varieties have been contrived to exclude these skin bacteria from the operative site. Textile drapes of towels or stockinette accomplish little beyond hiding the skin. Films of germicides or liquid plastic have not proved permanent enough to afford protection throughout a lengthy procedure.

Drapes of polyvinyl sheet with an adhesive surface have been useful, but the limited adhesive area makes application of such drapes difficult. It also predetermines the location, size, and shape of the incision. Adhesion to the skin is erratic and insecure.

The perfection of an elastic, transparent, persistently tacky adhesive permits the application of a polyvinyl sheet, 2 mm. thick, over the entire operative site. After the customarily wide disinfection of the skin, the area is flooded with isopropyl alcohol to assist in drying the surface. The sterile adhesive is then sprayed on the skin by the circulating nurse and is permitted to dry. The pink tint demarcates the adhesive area and assists in the application of a uniform coat.

The polyvinyl film is supplied as a roll, 24" x 42", interleaved with a special paper to assure penetration of steam during sterilization and to prevent sticking of the plastic.**

The roll is packaged in a paper sterilizing tube, one end of which is folded and sealed by the manufacturer to provide a sterile lip for extrusion of the roll onto the nurse's table. The opposite end is left open during the 30-minute exposure to saturated steam at 250°F. in the hospital sterilizer. The package is closed at the end of the sterilizing cycle by folding the paper tube on itself several times and sealing it with pressure-sensitive tape.

The polyvinyl sheet is unrolled on the nurse's table and held over the skin of the operative site by gloved and gowned assistants on either side of the field. It is smoothed on the skin with a gloved hand, beginning at the contemplated line of incision and working toward the periphery.

The textile operative sheet is then applied as usual. The adherent plastic sheet is incised with the skin. Because it is transparent, anatomic landmarks are readily recognized. When the operative findings dictate modification of the incision, extensions can be made. Secondary incisions can be located readily if the adhesive has been sprayed over a wide area.

When skin closure is imminent, the film is stripped from the edge of the wound to accommodate the sutures. The plastic is peeled off the skin at the end of the operation.

If the wound is drained or an enterostomy or marsupialization accomplished, the drape can be mobilized at the periphery and folded over the gauze to form an occlusive dressing. Patients in whom local anesthesia has been used have denied discomfort from removal of the plastic.

The polyvinyl usually pulls away from the adhesive. The latter remains on the skin as a protective film under adhesive tape or casts. It can be peeled off painlessly on the fifth or sixth postoperative day.

The film is sufficiently elastic to permit molding to anatomic contours. When a large convexity must be accommodated, such as the breast or head, the film can be preshaped by stretching it over an inverted dressing basin immediately prior to application. An extremity is draped by wrapping the film around it and rolling the redundant ends together opposite the incision. Spring clips such as are used on traction splints can be applied to hold the rolled plastic snugly.

The use of this plastic drape provides a bacteriologic barrier to exclude discharge from sinuses, fistulas, enterostomy, or unhealed wounds from the surgical incision. It provides a means of isolating gangrene and ulcer from the operative field. In head and neck surgery, the respiratory passages, anesthesia apparatus, and anesthetist's fingers are visible, yet barred from the aseptic area.

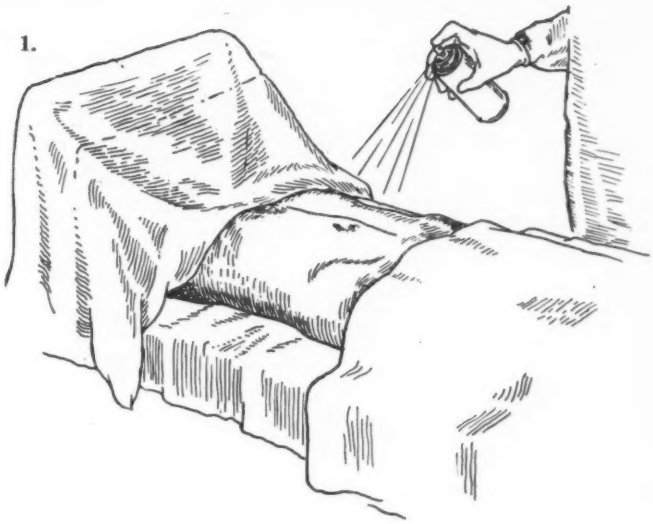
*From the department of surgery at the Peter Bent Brigham Hospital and the Harvard Medical School, Boston.

**The adhesive and drape are commercially available as Vi-hesive and Vi-drape from the Aeroplast Corp., Dayton, Ohio.

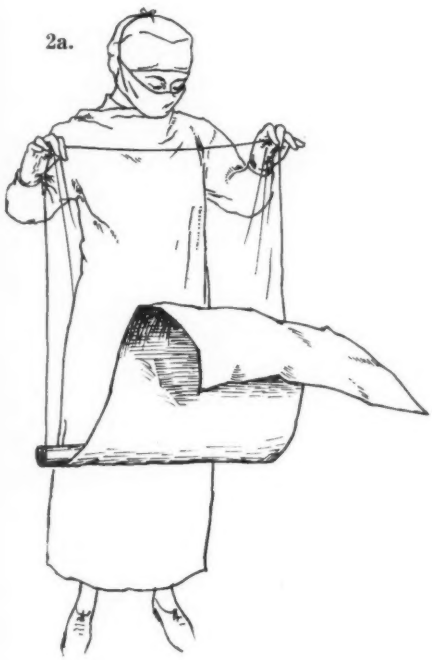
Technic For Use

1. Following disinfection of the skin, the operative area is blotted with a sterile folded towel to hasten drying. A uniform layer of sterile adhesive is sprayed from the dispensing container. The film becomes tacky in 20 to 30 minutes.

1.

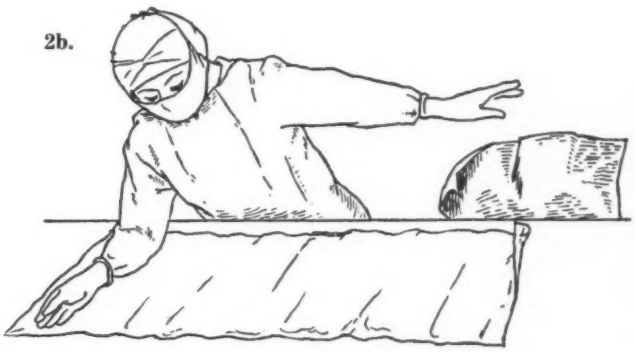


2a.

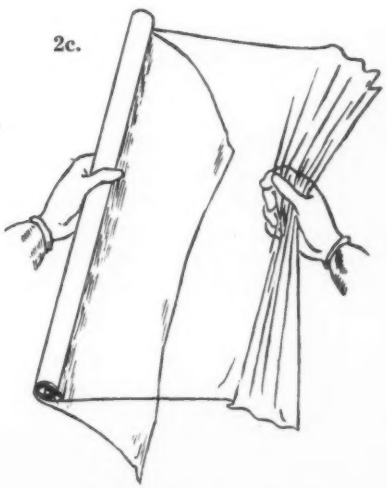


2. The plastic drape is extruded from the paper sterilizer tube onto the nurse's table. The drape is separated from the paper interleaf in various ways, as shown in 2a, 2b, and 2c.

2b.



2c.



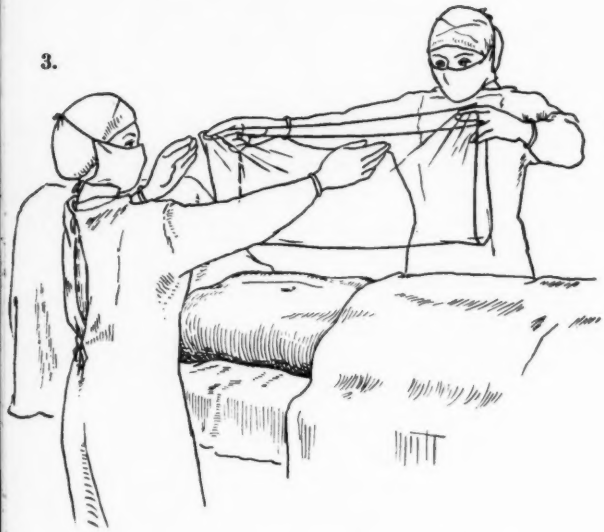
2a. The package can be unrolled so that the edge of the plastic can be grasped. The roll is then dropped and shaken to free the paper.

2b. The roll can be unrolled on a sterile table three to four inches to expose the plastic. The drape is pinioned to the table with the right arm while the left hand pulls the paper out as the drape unrolls on the table.

2c. The package can be unrolled to permit the plastic to be grasped in the right hand. The drape is gathered into the hand as the roll is played out of the opposite hand. The paper drops to the floor.

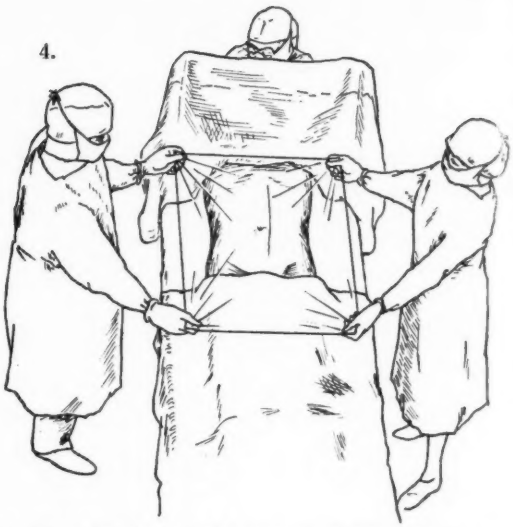
(Continued on next page)

3.



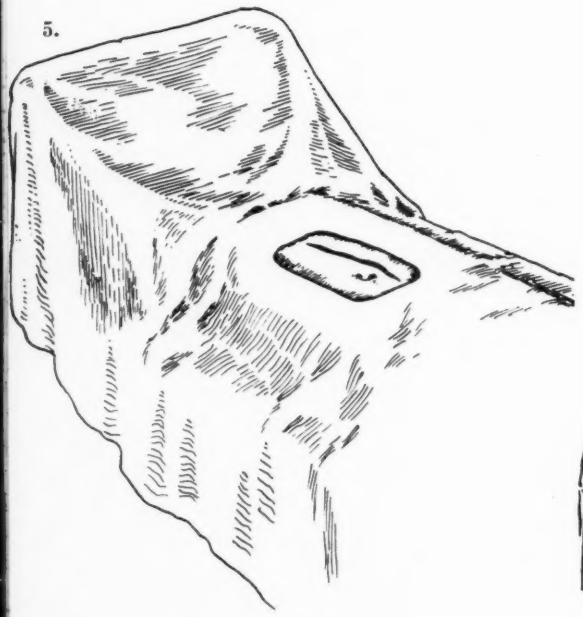
3. The drape is held lengthwise at the corners as it is passed across the operative field where the adhesive has been permitted to dry.

4.



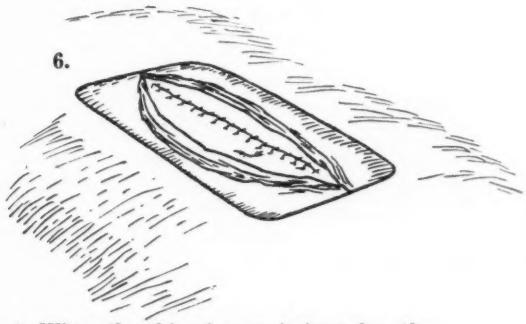
4. The plastic is held taut and lowered to the field. One hand is used to fix the film to the contemplated line of incision before smoothing it toward the periphery.

5.



5. Operative drape is applied in the customary manner. The incision is made through the plastic film.

6.



6. When the skin closure is in order, the film is peeled back from the wound edge to permit placement of sutures.

7.

7. After the wound has been dressed, the film is pulled off.

O.R. Procedure Manual For Open-Heart Surgery

By Audrey N. Bell, R.N.*

Introduction

• The first open-heart procedure at Parkland Memorial Hospital was performed in November, 1956. In January, 1957, when routines were becoming more established, we began writing this manual. The bound manual was printed in October, 1957, and 200 copies were available for distribution. These copies have been sent to many medical centers.

This procedure was developed for Parkland Memorial Hospital in conjunction with the Southwestern Medical School of the University of Texas, under the auspices of Hugh E. Wilson, M.D., assistant professor of surgery, cardiothoracic division. The manual is offered as a guide, to aid other hospitals in developing their own procedures.

Part I of the manual, "Preparation of Supplies and Equipment," appeared in the October issue. The third and final part of the manual, which will appear in the December issue, includes information on drugs, sutures, personnel assignments, and room arrangement for open-heart surgery.

Part II. Equipment and Supplies for Pump Team

Pump Team Pack

1 ring stand basin
2 gowns
4 towels
1 sheet
1 round basin—4"
24 flats, all-gauze
1 pair suture scissors
ATI Steamclox sterilizer control

Place above articles in ring stand basin for autoclaving. Wrap in two large muslin wrappers; label "Pump Team Pack."

Additional Equipment to be Placed in Room

2 large instrument tables; one to be draped with sterile sheet from pack
Intravenous standard
Small oxygen cylinders with regulator; 2 for children, 3 for adults
Suction tubing with copper connector
Plastic garden hose for filling Helix container
1 ring stand
Red wax marking pencil
Sterile gloves, sizes 7½ and 8
12 sterile rubber bands
Sterile #5 black silk tie spool—48"
2 cans Anti-Foam A spray
2 extension cords
1 roll 3" adhesive tape
Trays of sterile tygon tubing and connectors
Polyethylene filter bottle and 4 stainless steel sponges for children, 5 for adults
Heart-lung oxygenator and pump, complete with handles.

Equipment and Supplies for Venipunctures

2 venesection trays including 3 medicine glasses, labeled "Heparin," "Procaine," and "Zephiran," for each tray
Polyethylene catheters, assorted sizes — 15g, 16g, 18g, 20g, and 22g (catheters are to be opened as needed)
Sterile gloves, sizes 7½ and 8
500 cc. 5% dextrose in distilled water; attach infusion set, extension set, and 3-way stopcock
500 cc. isotonic sodium chloride with 2 cc. heparin, 10 mg./cc.; attach infusion set only
Hoffman clamps
2 intravenous standards
1 roll ½" adhesive tape

Set up each tray on a small square table. The heparin solution is to be connected to the arterial cannula; the 5% dextrose solution to be connected to the saphenous vein cannula.

Have two cannulae available for the brachial cut-down. One will be used for measuring bra-

(Continued on next page)

*Miss Bell is operating-room supervisor, Parkland Memorial Hospital, Dallas, Tex.

chial artery pressure; the other is for central venous pressure.

Tincture of Zephiran is used to prepare the areas for the cut-downs.

Instruments

Basic chest instrument set

Cardiac Instruments:

- Harken cardiac trocar and cannulae
- 2 Rumel tourniquets
- 4 patent ductus clamps (2 each, curved and straight)
- 2 coarctation spoon clamps
- 2 Kapp-Beck vessel clamps (small and large)
- 4 bulldog clamps, assorted lengths
- 1 spring-type bulldog clamp

Basic major soft-tissue instrument set PLUS

- 36 Kelly hemostatic forceps, curved
- 20 towel clips, 5¼"
- 10 towel clips, 3"
- 3 knife handles #3
- 2 knife handles #7
- 1 tissue forceps, 1 x 2 teeth, 5"
- 1 dressing forceps, smooth, 5"
- 2 tissue forceps, fine, 1 x 2 teeth, 7"
- 2 dressing forceps, fine, smooth, 7"
- 2 abdominal retractors, medium
- 2 abdominal retractors, large
- 2 tonsil suction tips
- 6 pediatric right-angled clamps, Mixter
- Sternal knife
- Mallet
- Sternal punch and teaspoon
- 1 set of 5 auricle clamps, 4 sizes
- 2 Gigli saws, 2 handles, guide
- 4 vein retractors
- 8 Halsted mosquito forceps, curved
- 1 nerve hook
- Commissurotomy scissors, right-angled
- Glover-Satinsky clamp with grooved ends
- 2 Wilson cardiac probes with eye in tip
- Gross clamp (optional)
- Gross atrial well (optional)
- Commissurotomy knives, set (optional)
- Valvulotomy knives (optional)

Scissors:

- 2 suture
- 2 curved Mayo
- 2 Metzenbaum, regular
- 1 Metzenbaum, baby (optional)
- 1 Iris, straight
- 1 wire
- 1 Metzenbaum, chest (optional)

Knife Blades:

- 3 #10 blades
- 2 #15 blades

Needle Holders:

- 4 New Orleans model, T-C jaws
- 4 Mayo, 8", T-C jaws
- 4 Mayo, 6", T-C jaws
- 2 Crile, 5", T-C jaws

If the patient is a child, the instruments are to be scaled downward in size, and the special pediatric rib-spreader is to be added. P.M.H. modified rib-spreader—up to 4 years of age; Wilson pediatric rib-spreader—4-10 years of age.

Linen Packs

Gown Pack:

- 6 surgeon's gowns
- 6 backs
- 25 surgical towels
- 2 sleeves
- ATI sterilizer control

Wrap in two large table covers; label "Gown Pack—Heart Surgery."

Drape Pack

- 1 laparotomy drape sheet
- 8 sheets
- 2 packs counted sponges, 10's
- 4 packs square packs, 4's
- ATI sterilizer control

Wrap in two large table covers; label "Drape Pack—Heart Surgery."

Syringe and Basin Set

(To be packaged in large instrument tray)

- 15 syringes, as follows (label syringes for drugs beforehand with Time tape; use Magic-Marker for writing on tape):
  - 7 10-cc. syringes labeled for drugs (see drug list)
  - 4 10-cc. syringes not labeled
  - 2 50-cc. syringes labeled "Potassium Citrate"
  - 2 30-cc. syringes labeled "Potassium Citrate"
- 17 medicine glasses—8 labeled for drugs, 9 not labeled
- 8 metal medicine glass holders labeled for drugs
- 2 3-oz. Asepto syringes
- 15 Kitner dissecting sponges
- 6 glass adapters—2 each ⅜", ¼", and Simms
- 3 3-way stopcocks
- 2 Patapar sheets, 36" x 36"
- 1 500-cc. graduate measure
- 1 small S/S basin labeled "Heparin Solution"
- 1 small S/S basin labeled "Saline" (for instrument stand)

1 square basin for "dirty" hemostats

1 8-oz. round basin

2 glass suction tips

Umbilical tape, 4 feet on bobbin—cut to desired length as needed

Hypodermic needles:

4 16g x 1½"

4 18g x 1½"

4 20g x 1½"

5 22g x 1½"

2 21g x 1½"

6 25g x 1½"

Suture needles:

4 French eye, figure 6, size 2

4 French eye, figure 6, size 3

12 Murphy

10 uterine cutting, large

4 surgeon's cutting #12

4 Mayo, large

6 Keith, 2⅞"

ATI sterilizer control

Wrap in two large muslin wrappers and label "Syringe and Basin Set—Heart Surgery." Include regular basin set when setting up a case.

Miscellaneous Basin—Rubber

(To be packaged in small instrument tray)

6 Penrose drains, ¼" width x 18" length

1 12' Birtcher cord with small angular ball tip

Chest drainage tubes: 2 each 28-fr, 22-fr, 20-fr, 18-fr, catheters

2 red rubber stoppers to fit test tubes

3 18" lengths latex tubing—1 each ⅜", 5/16", 3/16" diameter

2 suction tubing, 12 feet

1 suction tubing, 18 feet (for anesthesia to connect in induction room)

2 two-tube chest drainage tubing sets

Miscellaneous Equipment

3 Mayo stand trays, sterile

1 abdominal prep tray

2 chest drainage bottles, with holders (adult or child size, as needed)[1]

Dietetic scale for weighing sponges

Scale for weighing patient

Water bath

2 36" S/S catheter basins with covers

2 plastic suction tips with 4 holes in one end (drill with dental drill)

1 thermometer, sterile, for nurses' table

12 500-cc. isotonic sodium chloride, for pump team to prime Helix[2]

2 transfusion sets

3 Mayo stands

2 Ring stands

Birtcher electrosurgical unit

Ivalon, cut and pressed

Arterial and cava cannulae, assorted sizes 8 fr. to 26 fr.

2 calibrated suction bottles

1 can Anti-Foam A spray for suction bottles

2 500-cc. lactate Ringer's solution for irrigation (place in water bath)

Equipment to be weighed with patient: dressing, 2 Pean forceps, 4 needle electrodes, Levin tube, urethral catheter, 2 chest tubes, 1 roll ½" adhesive tape, arm board (plywood)

Levin tube, size according to patient

1,000-cc. S/S measuring pitcher, sterile

6 Hoffman clamps

Syringe Basin for Mixing Drugs

10 10-cc. syringes

1 2-cc. syringe

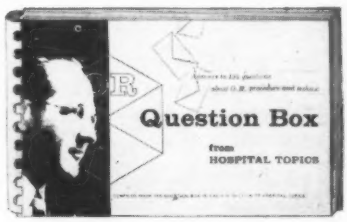
12 18 x 1½" hypodermic needles

Place in small square basin; wrap in muslin wrappers and autoclave. For use by circulating nurse in mixing and giving drugs to scrub nurse.

1. Child chest drainage bottles are made from 500-cc. intravenous solution bottles.

2. Heat to 200° F. in high-speed sterilizer.

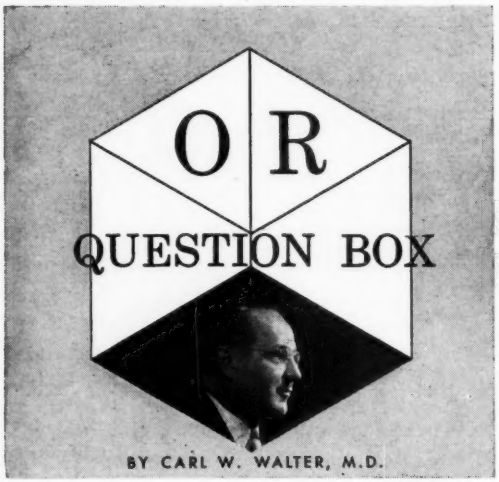
ORDER TODAY



O.R. QUESTION BOX
By Carl W. Walter, M.D.
$1.00

Authoritative answers to 195 questions most frequently asked on operating room procedure and technic, compiled from the author's regular column in HOSPITAL TOPICS. This book will be a valuable reference aid to operating room supervisors and staff, directors of nurses, medical staff members, central supply supervisors, and administrators who want to keep informed on good operating room practices.

Hospital Topics HT-1158
30 W. Washington St.
Chicago 2, Illinois
Please send me _____ copies of the O.R. Question Box at $1.00 each.
☐ Check is enclosed ☐ Bill me
Name_____
Address_____
City_____ State_____



Assisted by Dorothy W. Errara, R.N.

Q. Can a solution of two percent ethylene oxide be purchased ready for use?

A. Ethylene oxide can be purchased in liquid form from Distillation Products in Rochester, N. Y. Because it volatilizes at 10° C., it must be refrigerated below that temperature before the bottle is opened, and it must be handled in cold syringes or graduates. The two percent solution is readily made by adding two cc. of the liquid ethylene oxide to 1,000 cc. of cold normal saline.

Q. Do you think blankets have a high absorbency for ethylene oxide?

A. If the blankets are new and natural wool oils are present, there is a great deal of absorbency. If, however, the blankets have been laundered, there is practically none.

Q. What steps are taken to sterilize blankets before they are brought to the operating room?

A. Cotton blankets, which are routinely used in the operating room because of the hazard of accumulated static electricity in woolen blankets, come directly from the laundry to the surgery. If the hospital has an efficient laundering system, these blankets are sanitary and safe for use.

Q. Do you feel it necessary to shave patients for a D & C?

A. A heavy "beard" of pubic hair is hard to clean, particularly when blood accumulates there. Hence, the pubic shave before a D & C may not be essential bacteriologically, but from the point of view of patient comfort, it is very essential.

Q. Where should ventilating air enter the operating room?

A. Ideally, air should enter at the top of a room and be removed by positive pressure at the bottom, so that the stream of air flows constantly downward. This situation, however, is difficult to attain and is impractical where air-conditioning (cooling) is used.

Year-round conditioning of air is most readily accomplished by introducing tempered air at ceiling level and exhausting the vitiated air at a point lower than the inlet. With suitably located and directed louvers, the air currents can be made to pass across the top of the room and down the far side, and return across the floor to the wall in which the exhaust louvers are located.

Ten changes of air an hour suffice to maintain comfortable levels. Usually this rate can be accelerated to purge odors or unwanted vapors.

In the modern unfenestrated operating room, convectors are seldom used. Often the air exchange is accomplished at the top of the exposed wall, so that the exhausted air eliminates cold downdrafts.

Q. Is the ventilating plant for the operating room separate from that ventilating the rest of the hospital?

A. At one time, centralized ventilating plants were relied upon, but currently it is more common to provide a plenum chamber for various areas in the hospital. As a rule, each department (surgery, obstetrics, pediatrics, and others) will have its own plenum chamber provided with filtered air and a means for filtering and tempering the air—either with steam coils or refrigerating coils.

Q. There is considerable disagreement as to whether ventilating air should be 100 percent outside air or recirculated air. What is your opinion?

A. One hundred percent outside air is no solution to the problem of infection if housekeeping is poor. Sterile air picks up dust and its bacteria just as readily as unsterile air. In many areas, air must be recirculated for economy. Under these circumstances, removal of dust and bacteria with an electrostatic precipitator is essential to limit the spread of bacteria.

Q. Is it safe to exhaust air from the operating room through the sterilizing room?

A. Exhausting air from an operating room through the sterilizing room is an economical way of ventilating the latter. It need present no bacteriologic hazard in a well-managed suite in which the air count is less than 4-5/cu. ft. Individual organisms suspended in the air seldom settle out. It is the dust-borne organism that causes difficulty.

If economics are unimportant, sterile air should ideally be used in all aseptic areas. Unfortunately, this can be prohibitively expensive, and the compromise described is justifiable and safe.

Q. Who do you think should be "infection officer" in a hospital?

A. *Who* he should be is not important. He should, however, be an ingenious, hard-working, and suspicious person with authority to gather data, to suggest and institute programs of control. Often the well-known individual in a hospital, the "old friend" type, is ineffectual in this respect, and a complete outsider may have to be called upon to achieve significant results.

What every O.R. Nurse should know about A·S·R STERISHARP blades

Q. *What is a SteriSharp?*

A. It is a sterile-packed surgical blade made from a special alloy of extremely hard stainless steel. Like all stainless-steel surgical instruments it will not rust or corrode in hospital use.

Q. *Aren't all sterile-packed blades made from stainless steel?*

A. No, only SteriSharps. All others are made from ordinary carbon steel which rusts, corrodes and dulls quickly when autoclaved or kept in solution.

Q. *Are SteriSharp blades sharper than carbon steel blades?*

A. Yes. SteriSharps' imported high-chrome alloy Swedish steel is hardened, tempered, ground and sharpened under processes developed by A·S·R to give it a sharper, longer lasting cutting edge.

Q. *Can I autoclave the sealed SteriSharp packet?*

A. Yes. Neither autoclaving nor dry-heat sterilizing harms the packet or the blade inside. This means you can include any number of SteriSharp packets on the instrument tray. The sterile nurse can then open blades as needed. And all unopened packets can be returned to stock.

Q. *Can I autoclave SteriSharp blades out of the packet?*

A. Yes. Unlike carbon steel blades which blacken, rust and lose their edge when autoclaved, SteriSharp blades can be autoclaved repeatedly without damage. Thus, SteriSharps which have been opened but not used can be returned to stock. This eliminates blade waste. SteriSharps can be stored indefinitely without harm.

Q. *How does A·S·R make sure that SteriSharps are 100% sterile?*

A. SteriSharps are ultrasonically cleaned before packaging. The packets are sealed securely and are heat-sterilized at a time-and-temperature cycle well above highest hospital requirements. Each lot is sampled *twice*, and blades are tested for sterility by A·S·R's own bacteriologists according to USP XV (revised). Each lot is also checked by an independent laboratory.

Q. *How can I be sure SteriSharps come to me 100% sterile?*

A. Test them in your own laboratory. We will be happy to send you a detailed description of our sterility testing methods.

Q. *Can SteriSharps be re-used?*

A. After their work in the Operating Room, SteriSharps can be autoclaved and distributed to Pathology and other blade-using departments.

Q. *How do SteriSharps compare in cost with other sterile-packed blades?*

A. SteriSharps cost less.

Q. *How do SteriSharps compare in cost with ordinary carbon steel blades?*

A. SteriSharps do away with jars and solutions and eliminate blade waste. In addition, the greater durability of stainless steel means longer blade life. Surgeons report that during procedures where extensive cutting is required, one SteriSharp does the work of as many as six ordinary carbon steel blades. Hospitals using SteriSharps report dollar savings of 25% and more over conventional nonsterile carbon blades.

Q. *Do SteriSharps come in all standard sizes and fit all standard handles?*

A. Yes. In addition, when you contract for SteriSharps, you will receive FREE as many stainless-steel dispensers as you need for your O.R. suite and other blade-using departments.

Q. *How can I find out more about SteriSharps?*

A. Write: A·S·R HOSPITAL DIVISION, DEPT. HT, 380 MADISON AVENUE, NEW YORK 17, N. Y.

In Canada—A·S·R HOSPITAL DIVISION, 2055 DESJARDINS AVENUE, MONTREAL, CANADA

Literature and samples for your evaluation available upon request. If you have further questions—ask us.

A·S·R precision products

SteriSharps . . . the first and only sterile, stainless-steel surgical blade

• The "problem clinic," a popular session at every national AORN congress, was divided at the 1958 congress into two meetings—one for small hospitals (15 to 75 beds) and one for average and large hospitals. Questions from both these panel discussions have been selected to appear in this column. This month's questions were taken from the session for average and large hospitals.

PANEL: *Dean Theresa I. Lynch,* School of Nursing, University of Pennsylvania Hospital, Philadelphia, moderator.

L. Kraeer Ferguson, M.D., professor of surgery, Woman's Medical College of Pennsylvania and University of Pennsylvania Graduate School of Medicine.

Charles S. Paxson, Jr., administrator, Hahnemann Medical College and Hospital, Philadelphia.

Edward T. Lawless, M.D., anesthesiologist, St. Joseph's Hospital, Paterson, N. J.

Dorothy L. Hufcut, R.N., chief, nursing service, VA Hospital, Wilmington, Del.

Mary Jane Venger, R.N., director of nursing, Albert Einstein Medical Center, Philadelphia.

Sister Mary Albina, O.R.S., St. Agnes Hospital, Philadelphia.

Mrs. Doris Deimel, O.R.S., Rockaway Beach (N.Y.) Hospital.

Mrs. Lillian Sholtis Brunner, R.N., consultant in medical and surgical nursing, Bryn Mawr (Pa.) Hospital School of Nursing.

Q. Does the fire marshal inspect your operating room frequently, Mr. Paxson?

MR. PAXSON: In Philadelphia, the fire marshals make annual inspection. These inspections should generally be considered as minimum. We have our standards set for us by the underwriters, and we know what conditions should exist.

Q. The National Fire Protection Association has recommended that tinctures and ether not be used in the operating room in skin preparation. Our doctors were opposed to changing when I told them of this recommendation, as they said most hospitals have not changed or some have changed back to tinctures and ether. I would like to know what the majority are using.

SISTER ALBINA: Tincture of Zephiran is used routinely throughout our hospital. When ether is used, it is used outside the operating room. Ether is really not a disinfectant; it merely dissolves the fat.

DR. LAWLESS: I believe that recommendation was made by the National Fire Protection Association because patients have been burned on the operating table when flammable preparations placed on their skins have caught fire, from one cause or another.

DR. FERGUSON: I use ether in the operating room often, not routinely, but to take adhesive off or for various other reasons. I feel tinctures are definitely more useful than simple aqueous or detergent type of antiseptics.

I do not believe there is much of a fire hazard from the use of tinctures, or even of ether, in preparation of patients' skin for surgery.

Q. What is the place of the senior elective in the operating room, and how long should it be?

DEAN LYNCH: In some schools—for example, Vanderbilt University—the last 12 weeks are utilized for elective experience. Some students choose operating-room experience; some take public-health nursing. The full time is spent in the one elective. I believe that is the policy of most schools.

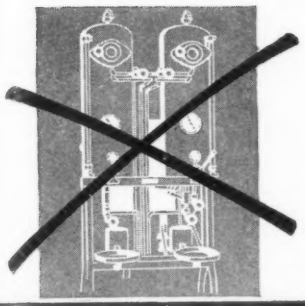
Q. Do you not feel that residents and interns should have the same type of formal training in aseptic technic that is required of nursing personnel functioning in the operating room, Dr. Ferguson? If so, who should teach them?

DR. FERGUSON: I agree that residents and interns should have training in this subject. However, this training really begins when they're just students.

Perhaps the training isn't as thorough and as good as one might desire. Nevertheless, when interns come into a hospital, they've been graduated from a modern medical school; they have already scrubbed in several operations; they've already been taught something, at least, of aseptic technic, so that the necessity for introducing them to a technic is not as great as it is for a student nurse.

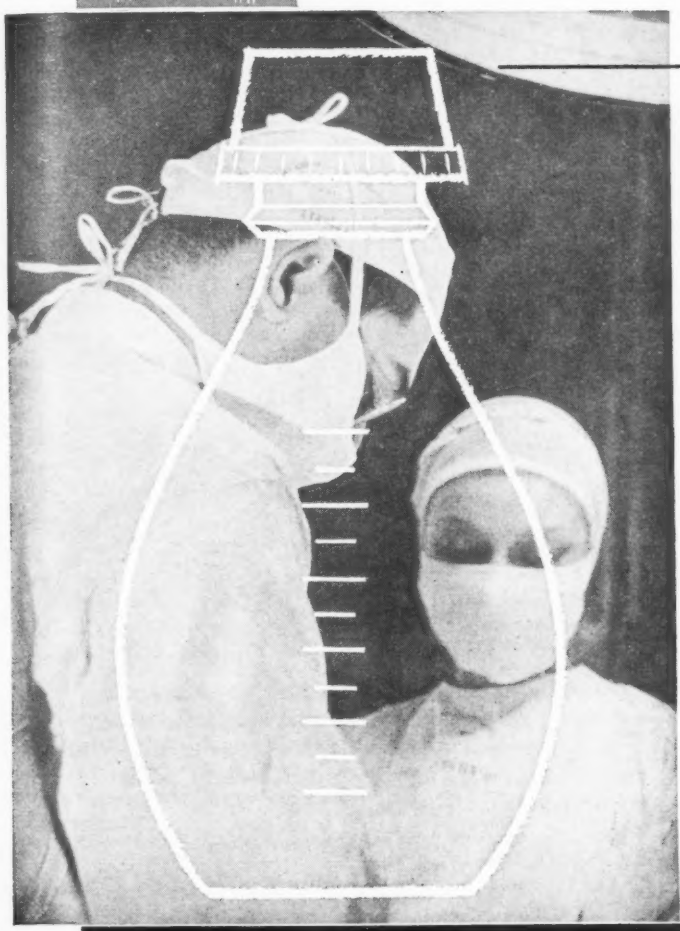
On the other hand, I agree that the aseptic technic learned in medical school is not always one which we would be willing to accept. Therefore, certainly when the interns and residents start in the operating room, they should be given a period of instruction. I don't believe this needs to take too long, and I think it can be done

(Continued on page 112)



Pour-o-vac

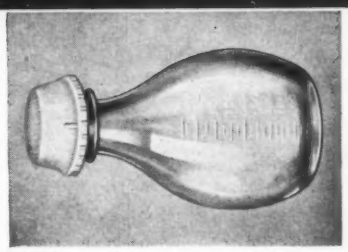
Sterile Fluid Flasking System



Eliminates the hazards of obsolete water sterilizers or makeshift fluids flasking methods . . . provides safe isotonic solutions in easy-to-handle containers . . . vacuum sealed to maintain sterility indefinitely . . . permits precise fluid temperature control . . . cost per use of less than two cents . . . the accepted technique in thousands of America's hospitals.

MACBICK

WRITE for literature and latest cost-reduction data on this modern POUR-O-VAC System.



THE MacBicK COMPANY

Formerly Macalaster Bicknell Parenteral Corporation

(DEPT. D) Broadway, Cambridge 39, Massachusetts

(Continued from page 110)

while the surgeon is scrubbing, if the resident or intern follows the surgeon in his technic.

I appreciate that the operating-room supervisor perhaps has more difficulty in watching out for this technic than the surgeon has, and I think that it's her province to inspect and to criticize and to insure conformance to the technic recommended by the hospital.

DR. LAWLESS: We would all benefit by formalizing some of our instruction in aseptic technic to our residents and interns upon their arrival at the institution, and not taking it for granted that they have picked up our particular procedure through association with the existing surgeons or their previous experience.

I think the very act of formalizing the instruction re-emphasizes the detail with which too frequently they are not familiar. Nurses are not really in a position to supervise them adequately.

DR. FERGUSON: I don't believe group instruction is practical. Suppose 18 or 20 interns and residents come to the hospital in June or July — these interns may not get into surgery until the following April. I think it is a waste of time to try to teach them aseptic technic or how to scrub in an operating room in July when they don't get around to surgery until April. Such instruction ought to be given when they come into the operating room.

MRS. BRUNNER: In one situation I was asked to give some instruction to the interns coming into the surgical service. They came to the operating room at an appointed hour, twice, and we went over our entire scrub technic. Then they repeated for me what I had told them, and I watched them and corrected their technic. Only then were they permitted to go into the operating room.

SISTER ALBINA: I believe that the intern and resident can be observed very well by the supervisor, and she can take the initiative to teach them the proper technic if they do not already know it.

Q. Why are operating-room supervisors considered impossible cranks?

SISTER ALBINA: The operating-room supervisor has many problems facing her at 7:30 in the morning. She has the nursing student to consider — has she made the proper assignments with the clinical instructor? If there is an anesthesia school, she has to consider the student in anesthesia.

If she gets a phone call that Miss So-and-So won't be in (probably the best scrub nurse), she has to make changes in the schedule immediately. Five minutes later the surgeon walks through the door with a cigarette. Ten minutes later Room No. 2 has not begun because the surgeon is 10 minutes late; 15 minutes later the practical nurse or the scrub technician calls to say she will not be in because she is ill.

The patient arrives; the preparation has been done very poorly. These are everyday problems. All supervisors must have them, because we're all dealing with human nature.

However, all of these problems can be solved smoothly if we have well-established and functioning administrating policies.

MRS. BRUNNER: I read a study recently of an operating room in which havoc practically reigned from day to day. When the situation was analyzed, it was found that a smooth-running operating room resulted when principles of organization were established and when there was proper delegation of responsibility so that the operating-room supervisor wasn't the only person who knew and did everything.

If the supervisor is disorganized and confused, her disorganization and confusion will be disseminated down to the lowest worker. On the other hand, if she is able to operate in a cool and collected manner, even the most trying situation can become a calm situation.

DR. FERGUSON: It takes an unusual person to be an operating-room supervisor — to be able to get along with all the various people who have to be dealt with.

The worst O.R. supervisor is the one who sees her job so clearly that she is not willing to bend with the many emergencies that arise in an operating room which make for tenseness and therefore personality clashes.

Q. How do you clean the abdomen of a patient returning to the operating room with a drain in place?

DR. FERGUSON: Our objective is to get rid of the skin bacteria, or the bacteria which have covered the skin from the drain. We cleanse the patient with the detergent we use to scrub our hands, scrubbing for three minutes. Then, if the detergent is something like pHisoHex, it's best not to use a tincture, but rather an aqueous Zephiran, because the tincture will take away the very property that you want to leave on the skin, by dissolving it.

To O.R. and O.B. SUPERVISORS:

If you fit this description —

- Well trained
- Experienced
- Confident of your administrative ability
- Ambitious to utilize your talents as fully as possible . . .

. . . then we believe we can help you find job satisfaction. Our goal is not immediate placement. We want to match a qualified person to an interesting position.

Your credentials will be carefully evaluated in an individual situation, and only if you qualify will you be recommended. Our proven method shields both employer and applicant from needless interviews, for we screen positions too.

Perhaps you are quite satisfied with your present position. On the other hand, if an opening occurs for which you are ideally suited, you—being an ambitious person—would like to have an opportunity to consider it. Filing your credentials with us would give you that opportunity—perhaps now, perhaps one year, two years, five years from now.

We do not advertise specific available positions, but we have many interesting openings. Our listings are confidential.

No registration fee

Mary A. Johnson Associates
(Agency)
11 W. 42nd St., N. Y. 36, N. Y.
LAckawanna 4-1565
Mary A. Johnson, Ph.D., Director

SELECTED BIBLIOGRAPHY

By Dorothy W. Errera, R.N.

Scurr, C. F.: "Accidents with Injections." *Brit. M. J.* 1:1289, June 2, 1956.

Multiple injection is almost inevitable in patient care and although unfortunate sequelae, at least as reported, are rare, the potential hazard is sufficient to warrant continuous and thoughtful technic.

Infections after injection run the gamut from superficial lesions to fatal deep abscesses. Heat-sterilized equipment, sterile solutions, and good technics of handling these, and vigorous disinfection of the site of injection do much to minimize the infection hazard.

Multiple-dose ampuls provide classical opportunity for peddling infection to patients. Antiseptic preservatives in solutions provide only a narrow margin of safety. A wider margin is achieved with rigid enforcement of immaculate technics for handling and entering the multiple dose ampul. Storage of ampuls at low temperatures is also advisable.

Individual-dose ampuls are the ideal and are mandatory in procedures involving intrathecal injection. Beware of so-called "sterile water" provided for rinsing or storing "sterile" syringes. Too often, the water is a grumous mass of bacteria. Sterile water or saline is only acceptable when it comes from an ampul or a sealed container.

Needles broken *in situ* are an injection nightmare. The risk is reduced by examination of every needle for flaws, cracks, or bends. A needle of sufficient calibre must be used for injection of a viscous solution. Breakage at the hub can be avoided by choosing a needle long enough to reach the correct tissue plane without burying the needle to the depth of the hub.

Sudden uncontrolled movement of the patient can cause a needle to break. Putting the patient in a comfortable position (seated or recumbent), and giving a warning at the moment of injection eliminate the likelihood of sudden movement. When a needle breaks during an injection, the fragment is removed if its position is obvious. But if extensive searching is likely to be necessary, removal must be done with full surgical facilities.

Confusion is easy in drug handling: Assonance causes mistakes in following verbal instruction; decimal points cause confusion in using the metric system. No useful purpose is served by coloring solutions.

Drugs are compounded to produce selective action, which requires selective injection routes. Accidental intravenous injection may cause respiratory depression or arrest, convulsions, loss of consciousness. The treatment is restoration of adequate oxygenation, by artificial respiration if necessary. A head-down tilt aids circulation; pressor drugs may be indicated. Convulsions may be controlled by the administration of a small intravenous dose of a barbiturate.

Certain drugs such as chlorpromazine and "depo" drugs, intended for the intramuscular route, are poorly tolerated by superficial tissues. An area with an adequate mass of recipient muscle and a needle of sufficient length to reach the muscle are essential for effective administration of the intramuscular drugs.

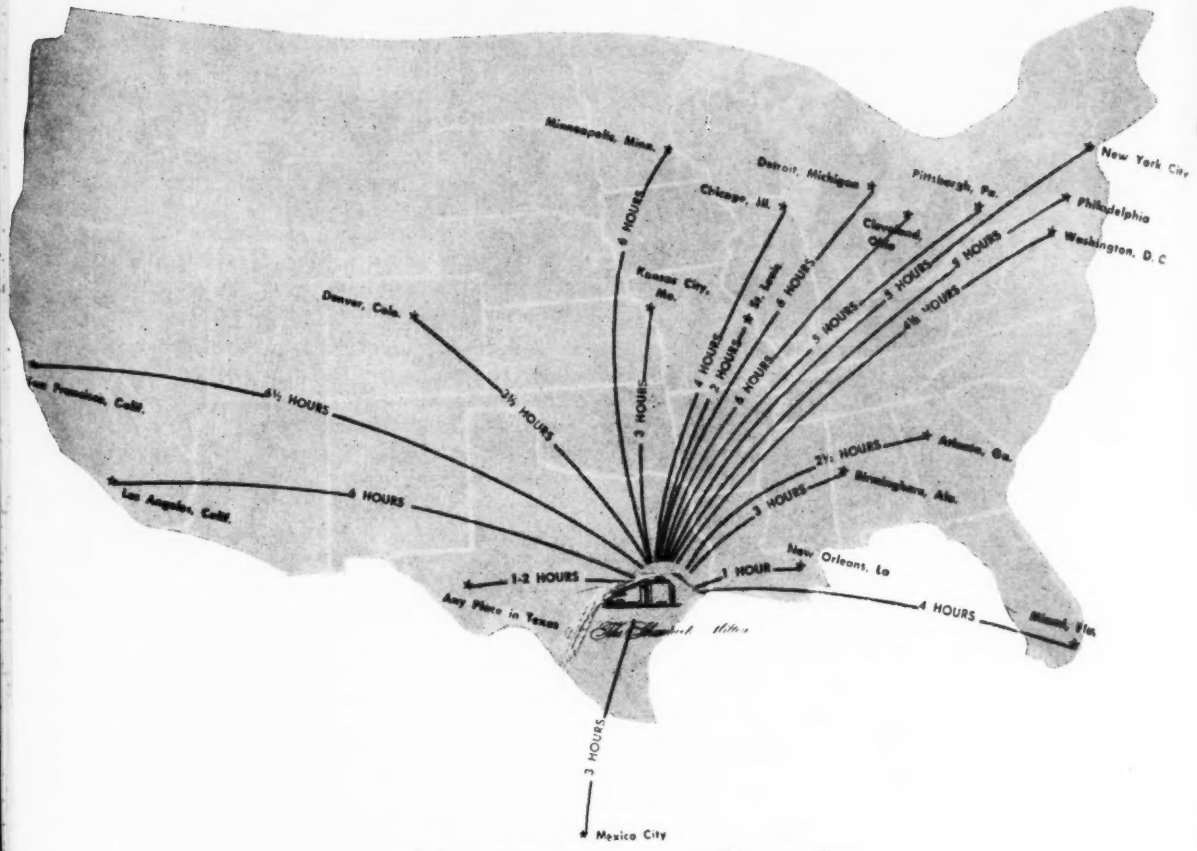
Nerves are ubiquitous in the body and accept trauma poorly. Not the least of these is the sciatic nerve in the gluteal region. This structure is spared injury by limiting injection in the area to the upper, outer quadrant of the buttock (*Editor's note*: As stated elsewhere, "that area covered by the man's hip pocket"), or by injecting in the antero-lateral aspect of the mid-thigh.

Extravenous injection of drugs intended for the intravenous route causes pain, necrosis, sloughing, and, in extreme situations, venous thrombosis. Oily solutions and suspensions intended for intramuscular injection and slow absorption may cause dangerous effects if they are injected into the blood stream or into a blood vessel. Giving the aspiration test before every subcutaneous or intramuscular injection will obviate much of this danger.

Using a short (45°) bevel needle for intravenous injection minimizes the risk of leakage and vein penetration. Selecting a needle of adequate calibre (#15) facilitates giving the aspiration test and makes unnoticed penetration of the far wall of the vein unlikely. After an accessible vein of good size, preferably in the lateral antecubital fossa, has been chosen and the needle inserted in the vein, a small amount of solution is injected. If the solution has been injected into an artery accidentally, the patient will complain of burning pain in the several seconds of waiting. In such a case the injection is stopped at once. Throughout the administration of an intravenous injection, the region of the needle point is watched for signs of extravenous injection.

Ecchymoses and hematomas are common sequelae of injections, especially when an imperfect needle is used. Applying firm pressure at the site of injection following removal of the needle will prevent extravasation of blood into the tissues.

Air embolism is unlikely when an ordinary syringe and needle technic is used. But embolism is very likely when needle holes are made in intravenous tubing, and most likely when these holes are made at a high level in the tubing.



Houston or Bust?

Try Your Skill in These Contests

IS "Houston or Bust" the slogan around your operating room these days? Well, a number of lucky girls are going to get to Houston for the sixth AORN Congress, February 9-11, and without going bust!

Three manufacturers, Austenal, Inc., Ethicon, Inc., and Johnson & Johnson, are sponsoring AORN convention contests, with all-expense trips to Houston as top prizes. So read the rules below, sharpen your pencils and your wits, and get on your way . . . to Texas.

Austenal, Inc.: Ten prizes for a useful idea or constructive suggestion concerning the use, handling, storing, or packaging of Vitallium surgical appliances and instruments. Open to all O.R. supervisors and nurses.

First award: All-expense trip to the convention. *Second:* Round-trip flight to the convention. *Third:* $100 cash. *Fourth* and *Fifth:* $75 cash. *Sixth* through *Tenth:* $50 cash. Address all entries to "Vitallium Viewpoint," Surgical Division, Austenal, Inc., 224 East 39th St., New York 16, N.Y. All entries must be postmarked before midnight, November 26, 1958.

Ethicon, Inc.: Six all-expense trips to the AORN congress, plus a $100 cash prize to each winner's O.R. supervisor.

Open to all actively-employed O.R. suture nurses other than supervisors or clinical instructors. Just complete a sentence starting, "Why don't they . . .," giving any suggestion or idea you feel will improve O.R. facilities, technics, supplies, or any other area of work. Suggestions may be on any aspect of the O.R.—not necessarily on sutures. Address "Why don't they. . . ." Contest, Ethicon, Inc., Somerville, N.J. Entries must be postmarked prior to midnight, December 15, 1958.

Johnson & Johnson: Winner will receive a round-trip plane or train ticket to the AORN congress, hotel accommodations, and will make radio and TV appearances. In addition, a 3-year nursing scholarship, equalling $500, will be presented in your name, and you will receive a bronze plaque commemorating the grant.

Open to all R.N.'s with at least six months' experience in surgery. In 100 words or less, tell what, or who, motivated you to enter a nursing career. Send entries to AORN Contest, Johnson & Johnson, New Brunswick, N.J. Contest closes November 30, 1958.

The $200,000,000 Texas Medical Center in Houston across parkway from hotel and convention hall.

Sixth National Congress

ASSOCIATION OF OPERATING ROOM NURSES

Shamrock-Hilton Hotel

Houston, Texas

February 9-12, 1959

MONDAY, FEBRUARY 9

Morning Sessions

8:30-11:00—Emerald Room

8:30 **Invocation**

8:40 **Address of welcome**

8:50 **Distinguished guest speaker**

9:30-11:00 **Carcinoma of the Lung**
Alton Ochsner, M.D., Professor of Surgery, Tulane University School of Medicine, New Orleans

9:30-11:00—Grecian Room

9:30-11:00 **Recent Developments in Ocular Surgery**
Louis J. Girard, M.D., Professor of Ophthalmology, Baylor University College of Medicine, Houston

9:30-11:00—Continental Room

9:30-11:00 **Problem Clinic for Small Hospitals**
MODERATOR—Mrs. Margaret Ponds, R.N., Director of Nursing, Heights Hospital, Houston
Participants:
SURGEON—Earl Clawater, M.D., Medical Center Hospital, Tyler, Tex.
ANESTHESIOLOGIST—Sharon Storey, M.D., Heights Hospital, Houston
ADMINISTRATOR—Horace Cardwell, Lufkin Memorial Hospital, Lufkin, Tex.
DIRECTOR OF NURSES—Dorothy Swichheimer, Victoria Hospital, Victoria, Tex.
OPERATING-ROOM SUPERVISOR—Mavis Pate, R.N., Medical Center Hospital, Tyler, Tex.

11:00- 3:00 **Viewing of Exhibits**

Afternoon Session

3:00-5:30—Emerald Room

3:00- 4:15 **Thoracic and Abdominal Aneurysms**

Michael DeBakey, M.D., Professor of Surgery, Baylor University College of Medicine, Houston

4:30- 5:30 **AORN Business Meeting**

TUESDAY, FEBRUARY 10

Morning Sessions

8:30-11:00—Grecian Room

8:30- 9:45 **Recovery and Postanesthesia Units**

PURPOSE AND TYPE OF CARE TO BE RENDERED

M. T. Jenkins, M.D., Anesthesiologist, University of Texas Southwestern Medical School, Dallas

ADVANTAGES

Jerry A. Stirman, M.D., Assistant Professor of Surgery, University of Texas Southwestern Medical School, Dallas

STAFFING

Audrey Bell, R.N., Operating-Room Supervisor, Parkland Memorial Hospital, Dallas

10:00-11:00 **Panel Discussion: Pitfalls in the Planning of an Operating-Room Suite**

Moderator: Mrs. Doris Deimel, R.N., Operating-Room Supervisor, Rockaway Beach Hospital, Rockaway Beach, N.Y.

Participants:

Mrs. Marie B. Ellison, R.N., Operating-Room Supervisor, St. Luke's-Texas Children's Hospital, Houston

Elizabeth Saunders, R.N., Operating-Room Supervisor, University of Texas Medical Branch Hospitals, Galveston

8:30-11:00—Continental Room

8:30-10:00 **Panel Discussion: Teaching Programs**

Moderator: Frances Brush, R.N., Director of Nursing, Methodist Hospital, Houston

GRADUATE NURSE PROGRAM

Sister Mary Vincent, Santa Rosa Hospital, San Antonio, Tex.

PROFESSIONAL STUDENT PROGRAM

Speaker to be announced

TECHNICAL AIDE PROGRAM

Maj. Jeanne B. McCormick (ANC), Brooke Army Hospital, Fort Sam Houston, Tex.

10:00-11:00 **To be announced**

8:30-11:00—Emerald Room

8:30-11:00 **Panel Discussion: Radiation Protection**

Staff of the University of Texas M. D. Anderson Hospital and Tumor Institute, Houston

PRINCIPLES OF RADIATION PROTECTION

Warren Sinclair, Ph.D., Head, Department of Physics

OPERATING-ROOM PROCEDURES IN RADIOTHERAPY

Lowell Miller, M.D., Assistant Radiotherapist

NURSING RESPONSIBILITY FOR RADIATION PROTECTION AND PATIENT CARE

Renilda Hilkemeyer, R.N., Director of Nursing

THE ROLE OF OPERATING-ROOM NURSING PERSONNEL

Imogene Creber, R.N., Operating-Room Supervisor

APPLICATION OF RADIATION TECHNICS

Color telecast from operating room, University of Texas M. D. Anderson Hospital

11:00- 3:00 **Viewing of Exhibits**

Afternoon Session

3:00-5:00—Emerald Room

3:00- 5:00 **Today's Problem of Infections**

HAND SCRUBS AND SKIN PREPARATIONS

Philip B. Price, M.D., Dean, University of Utah College of Medicine, Salt Lake City

MANAGEMENT, PREVENTION, AND CONTROL

Ellard M. Yow, M.D., Professor of Medicine, Baylor University College of Medicine, Houston

WEDNESDAY, FEBRUARY 11

Morning Sessions

8:30-11:00—Grecian Room

8:30- 9:30 **Restoration of Hearing by Surgical Technics**

Fred Guilford, M.D., Clinical Assistant Professor of Otolaryngology, Baylor University College of Medicine, Houston

9:45-11:00 **Intergroup and Interpersonal Relations**

8:30-11:00—Continental Room

8:30- 9:50 **The Operating Room as a Research Laboratory in the Care of Severe Burns**

Truman G. Blocker, M.D., Professor of Plastic and Maxillofacial Surgery, University of Texas Medical Branch, Galveston

10:00-11:00 **Utilization of the Housekeeping Department by the Operating Room**

Euna Brown, R.N., Executive Housekeeper, University of Texas M. D. Anderson Hospital and Tumor Institute, Houston

8:30-11:00—Emerald Room

8:30-10:00 **It Could Happen to You!**

Malpractice Suits and Insurance Coverage for O.R. Nurses

Helen Creighton, R.N., J.D., Assistant Professor, Georgetown University School of Medicine, Washington, D.C.

10:10-11:00 **Area Sterilization**

John C. Gabel, Wilmot Castle Co.

11:00- 3:00 **Election of Officers**

Polls will be open to delegates during this time

11:00- 3:00 **Viewing of Exhibits**

Afternoon Sessions

3:00-5:30—Emerald Room

3:00- 4:30 **Roadblocks to the Supply of Graduate Nurses in the Operating Room**

MODERATOR: Mary V. Schwendeman, Editor, "ORS"

Participants:

SURGEON—R. Lee Clark, Jr., M.D., University of Texas M. D. Anderson Hospital and Tumor Institute, Houston

ANESTHESIOLOGIST—Charles Allen, M.D., Chief Anesthesiologist, University of Texas Medical Branch Hospitals, Galveston

NURSING EDUCATOR—Faye Pannell, R.N., Dean, School of Nursing, Texas Women's University, Parkland Memorial Hospital, Dallas

DEAN OF NURSES—Virginia M. Brantl, R.N., University of Texas Medical Branch Hospitals, Galveston

OPERATING-ROOM SUPERVISORS—Sister Mary Giles, R.N., St. Mary's Hospital, Kansas City, Mo.; Mary Roberts, R.N., Veterans Administration Hospital, Dallas

CONSULTANT—Alice R. Clarke, R.N., Editorial Consultant, Hillsdale, N.J.

4:30- 5:30 **AORN Business Meeting**

THURSDAY, FEBRUARY 12

Morning Session

8:30-11:00—Emerald Room

8:30-11:00 **Special Program on Open-Heart Surgery**

Review of Anatomy and Pathology

Set-up of Operating Room

Closed Circuit Telecast from University of Texas M. D. Anderson Hospital and Tumor Institute

2:00 p.m. **Meeting of National AORN Board of Directors**

TUESDAY, FEBRUARY 10 and WEDNESDAY, FEBRUARY 11

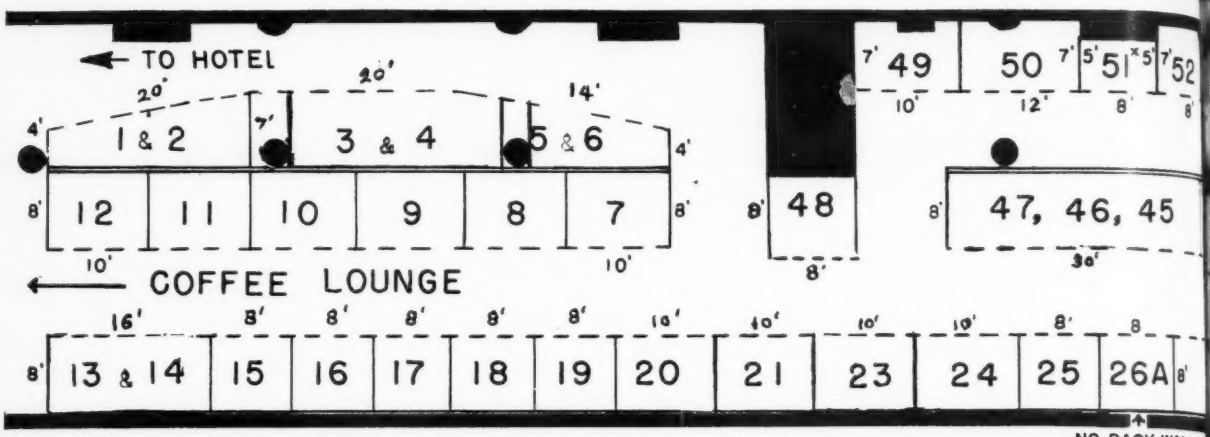
8:30-11:00—Bluebonnet and Azalea Rooms

8:30-11:00 **Round-table Discussions on Sterilization of Supplies**

Consultants:

Charles Artandi, Ph.D., Ethicon, Inc.
Velma Chandler, Ph.D., Ethicon, Inc.
John C. Gabel, Wilmot Castle Co.
Henry P. Hamrock, The MacBick Co.
Charles Kendall, Becton, Dickinson and Co.
M. G. McBane, Wilmot Castle Co.
John J. Perkins, American Sterilizer Co.
Edna A. Prickett, R.N., American Sterilizer Co.
George F. Reddish, Ph.D., Consultant, Vestal, Inc.
Earle H. Spaulding, Ph.D., Consultant, Becton, Dickinson and Co.
Mrs. Ethel I. West, R.N., Operating-Room Supervisor, Methodist Hospital of Southern California, Arcadia, and Consultant, Aseptic Thermo Indicator Co.

In December: More highlights of the program and full details on the scientific exhibits.



ASSOCIATION OF OPERATING ROOM NURSES

SHAMROCK-HILTON — HOUSTON, TEXAS

FEBRUARY 9, 10, 11—1959

The exhibit hall is adjacent to the hotel and so convenient that everyone will find it easy to attend the exhibits. Luncheon will be served daily in the hall.

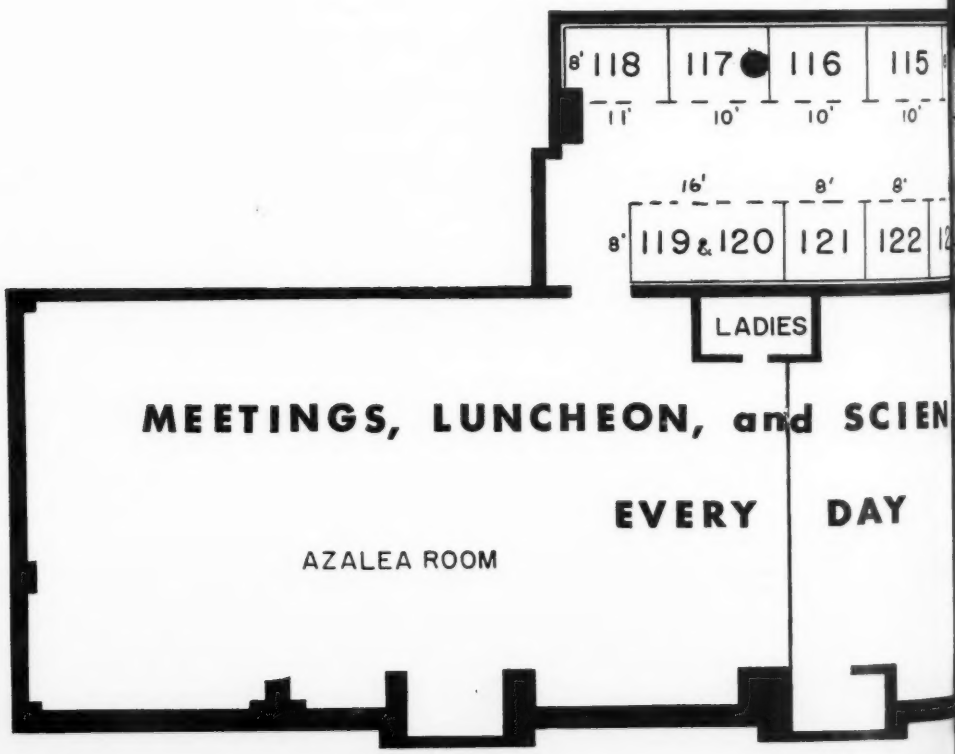
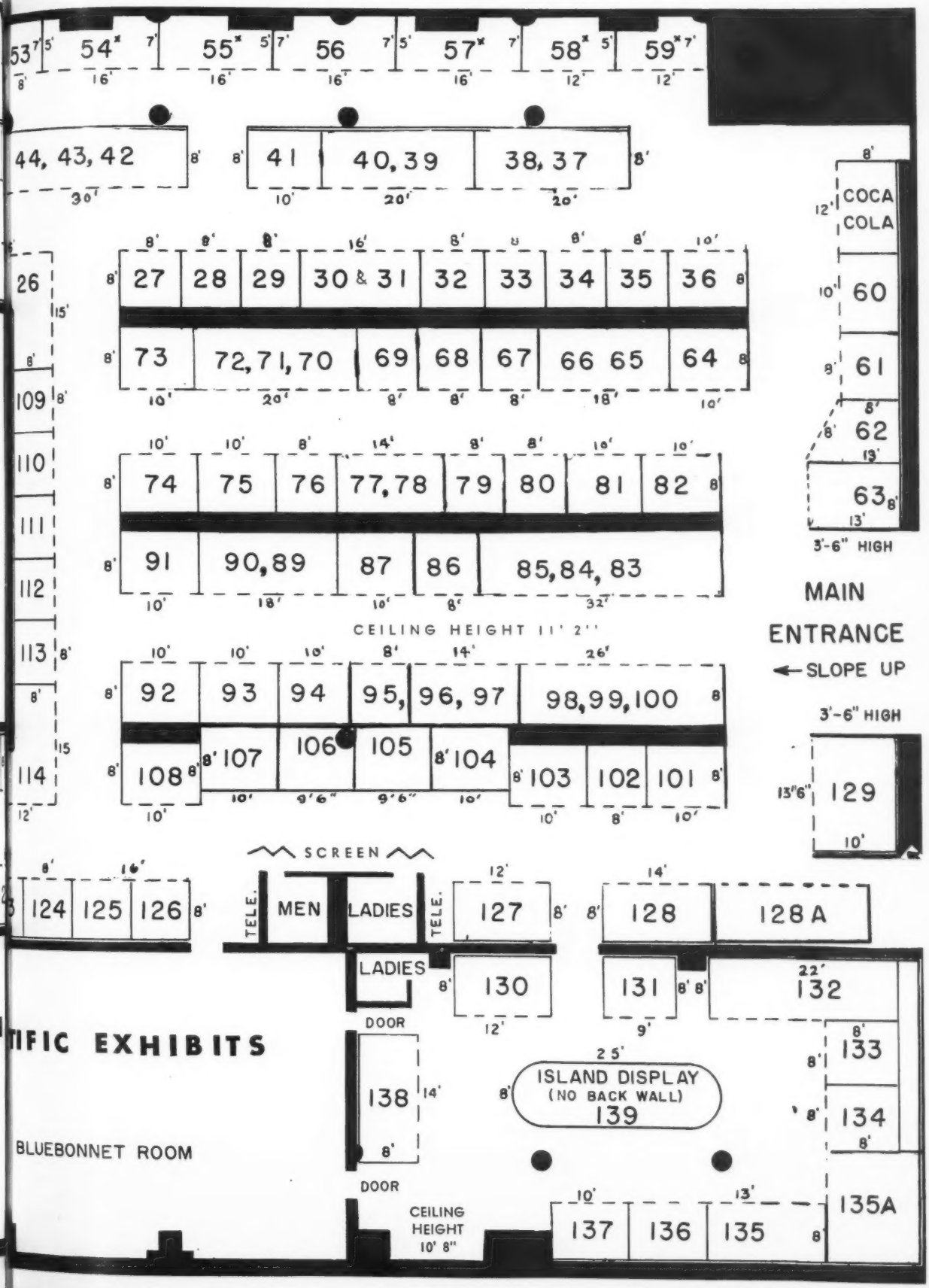


EXHIBIT AREAS



SCIENTIFIC EXHIBITS

Introducing

AORN Technical Exhibitors

These carefully selected technical exhibitors will be on hand to give you on-the-spot answers to your operation and maintenance problems, and to show you how you can utilize their operating-room supplies and equipment most effectively. Well-qualified representatives will be glad to demonstrate fully any product, apparatus, or attachment. Exhibit hours will be 11 a.m. to 3 p.m. daily, Monday through Wednesday. No meetings have been planned for these hours so that you may take full advantage of this opportunity to see these products and solve your problems.

Abbott Laboratories, North Chicago, Ill. Booth 93. Exhibited will be a complete line of prepared intravenous solutions, Pliapak plastic blood bottles, and disposable equipment. Pentothal sodium, Quelicin, and procaine products will also be featured.

Admiral Hospital Products Corp., Detroit. Booths 3, 4. Sterile disposable syringes of all sizes, with variety of needle sizes, will be highlighted in display of company's line of disposable hospital products.

Aeroplast Corp., Dayton, O. Booth 10. New products, Vi-Drape surgical film and Vi-Hesive surgical adherent, will be shown. Representing a new aseptic technic, they provide a sterile operative field, eliminate skin towels and clamps. Surgical incision is made through the sterile Vi-Drape film, adhered to the skin with sterile Vi-Hesive adherent; patient's skin is completely isolated from operative site.

Alcon Laboratories, Inc., Fort Worth, Tex. Booth 137. Steri-Units, a new, sterile, single dose disposable unit, containing drugs especially prepared for ocular surgery, will be featured. Nurses are invited to discuss Steri-Units or any problems of ophthalmic medication with representatives.

A. S. Aloe Co., St. Louis. Booth 105. Exhibit will feature Alumiline, light, functional hospital furniture, completely static, conductive, and noncorrosive.

American Cyanamid Co., Surgical Products Division, Danbury, Conn. Booths 125, 126. Manufacturers of Davis & Geck sutures and other surgical products and VIM hypodermic needles, syringes, and specialties. Featured will be Surgilar and Surgilope SP — new non-glass suture packagings; new Elliptron atraumatic needle; and Surgaire, sterile deodorant spray ointment for surgical wounds.

American Cystoscope Makers, Inc., New York City. Booth 82. Visitors are invited to view the exhibit, where representatives will offer suggestions on care and maintenance of telescopic instruments, and discuss sterile packed inflatable catheters, disposable latex urinals, and colostomy and ileostomy devices.

American Hospital Supply Corp., Evanston, Ill. Booths 98, 99, 100. Displayed will be the complete line of hospital supplies and equipment; highlights include sterilizing technics available with new printed wraps and envelopes, some divided, some self-sealing; demonstration of the Tomac ultrasonic washer with automatic washing and rinsing; and Tomac conductive sole shoes, available in several styles and colors.

American Sterilizer Co., Erie, Pa. Booths 83, 84, 85. Exhibited will be the newest equipment for surgery, including tables and lights. Ultrasonic cleaner for instruments will be demonstrated; new utensil washer-sanitizer, sterilizers, and other allied equipment will be displayed.

Anchor Products Co., Addison, Ill. Booth 109. Items shown will include Anchor brand line of "Electro Polished" stainless steel surgeon's needles; hospital needle cabinets with new concave drawers; stainless steel sterilizing boxes; and needle racks. Visitors are invited to discuss their needle problems with representatives.

Aseptic Thermo Indicator Co., North Hollywood, Calif. Booth 68. Displayed will be Steam-Clox and Sterilometers—indicators for proof of proper sterilization; SteriLine syringe, needle, and catheter sterilizing bags, and needle and catheter holders. Introduced will be SteriLine nipple caps for terminal sterilization of infant formulas; SteriLine paper tubing and pressure-sensitive labels, both with built-in indicator; and bag closettes.

A.S.R. Products Co., New York City. Booths 60, 61. Visitors are invited to see stainless steel SteriSharp blades in the new package, and to stop and discuss blade handling technics. Also of interest will be A.S.R. surgical soap, hexachlorophene soap made with a cosmetic base. Samples will be available.

Austenal, Inc., New York City. Booth 24. Be sure to see the many new Vitallium surgical appliances and instruments. Of current interest will be a display of Vitallium hip prostheses and instruments used in hip arthroplasty. Also view the growing line of autoclave-proof Vitallium Kool-Grip instruments.

C. R. Bard, Inc., Summit, N. J. Booths 31, 32. New prostheses of Teflon will be featured, including arterial grafts, tissue replacement mesh, and intra-

cardiac patches. Catheters for use with the pump oxygenator will be shown, as well as Bardex sterile packaged balloon catheters, a complete line of Bardic plastic products, waste collection bags, and a variety of drains.

Bard-Parker and Co., division of Becton, Dickinson and Co., Rutherford, N.J. Booth 43. Visitors are invited to see the Bard-Parker sterile Rib-Back blades in the puncture-proof foil package. Manufactured from time-tested carbon steel, the sterile package may be autoclaved if desired.

Barnes-Hind Ophthalmic Products, Inc., Sunnyvale, Calif. Booth 121. Minims, a new concept in packaging of ophthalmic solutions, will be shown. Minims are sterile disposable units of sterile ophthalmic solutions for emergency and hospital wards, and surgery. Sterility and potency of the solutions are maintained indefinitely.

Bauer & Black, division of the Kendall Co., Chicago. Booths 64, 81. Exhibited will be the new line of Curity sutures in packets, featuring a complete line of absorbables and nonabsorbables, needled items, and standard lengths. Also shown will be the Curity radiopaque sponge, designed for safer sponging technic, and the company's other surgical dressings.

Baxter Laboratories, Inc., Morton Grove, Ill. Booths 70, 71, 72. Visitors are invited to view several new Baxter parenteral fluids and administration sets, designed specifically to meet operating-room needs. The Travenol Division will display the twin-coil artificial kidney, and the latest detailed information on the role of the nurse in hemodialysis will be available.

Becton, Dickinson and Co., Rutherford, N. J. Booth 44. Visitors are invited to see the new Discardit line of products. Featured will be the Yale sterile disposable needle and Hypak sterile disposable syringe and needle combination, the B-D sterile lancet, and other products. Also on display will be reusable Multifit and Yale needles, and Ace elastic and adhesive bandages. Newest product is Ace aerosol adherent.

The Birtcher Corp., Los Angeles. Booth 59. Featured will be new Model 360 cardioscope for diagnosis and continuous monitoring of surgical procedures, and Model 300 electrocardiograph with two speeds, one-hand operation, standard size trace, transistorized printed circuits.

S. Blickman, Inc., Weehawken, N. J. Booths 77, 78. A complete line of Blickman-built stainless steel electrically conductive operating room furniture will be displayed. Included will be stainless steel cabinets for the operating room, featuring the new instrument hook. The newly published Blickman operating-room equipment catalog will be available at the booth.

John Bunn Corp., Buffalo, N. Y. Booth 9. Equipment for complete glove-processing will be displayed. Featured will be the Bunn glove tester, with its own compressor, which enables operator to locate pinholes and weak spots in surgical gloves. Ultrasonic cleaner, which processes needles, syringes, and instruments by sound waves, will also be shown.

Wilmot Castle Co., Rochester, N. Y. Booths 110, 111, 112. Displayed will be four pieces of new equipment: the 650 ultrasonic cleaner and its companion, the 651 ultrasonic dryer; the 1630 Sterox-O-Matic gas sterilizer; and the #100 Ultra-Flex operating-room table. In addition, on a special light rack, will be an assembly of lights, including the 62P, 69, 685, 581 general light, 582 emergency power unit, and the 52P Safelight.

Chesebrough-Pond's Inc., New York City. Booth 41. The makers of prepackaged, pretested, dependable Vaseline sterile petroleum gauze will show the newly developed size, which is a dual-purpose dressing. A ready-to-dispense 3" x 3", 3-ply pad, it can also be opened to become a 3" x 9" strip.

Gilbert Hyde Chick Co., East Paterson, N. J. Booth 130. Exhibited, with live models, will be the new model DVHI-DV orthopedic and surgical table, with many improvements. Also shown will be the Davis patient roller, and other models of fracture tables, including the Bell and Doctor Virgin tables, and Chick variety infant cast table.

Chilean Iodine Educational Bureau, Inc., New York City. Booth 87. The exhibit will call attention to the value of iodine and iodine preparations in surgery, medicine, nutrition, and sanitation. Reprints and other services of the bureau are offered without cost or obligation.

Clay-Adams, Inc., New York City. Booth 124. Featured will be Ioclide,

(Continued on next page)

For Patient Protection

The New Posey "Patient Aid"
The new Posey "Patient Aid" is another rehabilitation product which encourages self-exercise and is a positive aid to the geriatric. The patient can raise himself without calling for the nurse.
Catalog #B-654 (For open end beds) $5.95 each. Catalog #B-654A (For beds with solid foot ends) $5.95 each.

Posey Patient Support
Standard Model: PP-753, $6.75.
Adjustable Model: PP-154, $7.50.
Gets your patient out of bed . . . useable with both wheelchairs and conventional chairs.

McDonald Restraint
Standard Model: P-4147, $6.15. Extra-heavy model: P-353. Riveted construction with keylock buckles, $19.80 each. Keeps patient in bed.

SEND YOUR ORDER TODAY
And Write for Illustrated Literature About Other Posey Hospital Equipment

J. T. POSEY COMPANY
2727 E. Foothill Blvd.
Dept. HT
Pasadena, California

new iodophor germicide concentrate for killing spores, viruses, bacteria (including tubercle bacilli), and which is effective against resistant strains of staphylococci; sterile Intramedic polyethylene tubing in a wider range of sizes and lengths; the new, sterile, ready-for-use Intramedic luer-stub adapter, a blunt cannula, designed for use with polyethylene tubing; and other selected operating-room specialties.

The Coca-Cola Co., New York City. Ice-cold Coca-Cola served through the courtesy and co-operation of the Houston Coca-Cola Bottling Co., Houston, Tex., and The Coca-Cola Co.

Codman & Shurtleff, Inc., Boston. Booth 34. A complete line of standard surgical instruments will be shown, together with many newly developed instruments for use in the neurosurgical, orthopedic, thoracic, and cardiovascular fields, and in other specialties.

Connecticut Bandage Mills, Bridgeport, Conn. Booth 116. Displayed will be examples of the company's elastic bandages, splints, traction equipment, and disposable examining gloves.

Cutter Laboratories, Berkeley, Calif. Booths 13, 14. The newly announced Cutter Saftisyringe will be on display. Visitors are invited to stop and discuss the safety, convenience, and economy of the new syringe, available in three sizes, with and without needle. Also shown will be the line of intravenous solutions, expendable sets, blood banking equipment, and Cutter Enemol.

Davol Rubber Co., Providence, R. I. Booths 39, 40. Professional Products Division will display the latest additions to the line of surgical and hospital products, including the new Epstein nasopharyngeal airway; Dale-Schwartz rebreathing tube; Buyers sump drain; and Bizzarri-Giuffrida endoesophageal tube. In addition, representatives will show conductive rubber accessories, and a complete assortment of plastic surgical tubes and catheters.

J. A. Deknatel & Son, Inc., Queens Village, Long Island, N. Y. Booth 18. Displayed will be the Deknatel needled sutures in the transparent Plastic Pak, providing fast, simple handling with no change in O.R. sterility technic. Pack is sterilized in formaldehyde as are glass tubes. Direct visual assurance of sterility affords safety. Also featured: Deknatel 'K' needle, the all-purpose needle with the revolutionary new point designed for sharpness and control.

De Puy Mfg. Co., Inc., Warsaw, Ind. Booth 103. Visitors are invited to talk with representatives and inspect the latest innovations, instruments, and technics used in orthopedic surgery. Representatives will be pleased to discuss problems and ideas with individual nurses.

Deseret Pharmaceutical Co., Inc., Salt Lake City. Booth 25. Presented will be a revolutionary idea in methods of intravenous therapy. The new Deseret Intracath is a disposable unit which places a soft, pliant, vinyl plastic catheter within the vein with the simplicity of making an ordinary venipuncture. No scrubbing or gloving of the hand is necessary.

Dittmar and Penn Corp., Philadelphia. Booth 75. Exhibited will be many additions to the line of surgical instruments for use in neurosurgery, and cardiovascular, thoracic, and general surgery. Highlighted will be improved technics in manufacturing many types of general operating retractors and other instruments.

Doho Chemical Corp., New York City. Booth 27. Exhibited will be Turgasept, ionic deodorizer aerosol spray which neutralizes odor without floral masking or substitution. Bactericidal and fungicidal, it was formulated primarily for use in hospitals and other institutions, but can be used in any type of malodor condition.

Duke Laboratories, Inc., South Norwalk, Conn. Booth 49. Displayed will be Elastoplast, stretchable, adhesive-surfaced bandages and unit dressings; Gelocast, a prepared Unna-paste bandage; Nivea Creme, Nivea skin oil and basis soap for patients with dry, sensitive skin.

Eisele & Co., Nashville, Tenn. Booth 32. Company's new control type syringe will be featured. Also displayed will be both regular and interchangeable hypodermic syringes, clinical thermometers, hypodermic needles, Eco bandage, and specialty glassware.

Ethicon, Inc., Somerville, N. J. Booths 45, 46, 47. Electron sterilized surgical gut, stronger, more pliable, easier to handle, and new easy-open foil suture packages will be featured. Exclusive collagen pure, tru-chromized, tru-gauged properties of Ethicon surgical gut will be demonstrated, as well as a complete line of Atraloc needle sutures for every surgical need. Trupermanized surgical silk and surgical cotton, along with other surgical specialties, will also be shown.

The Fengel Corp., New York City. Booth 107. Emphasized in the exhibit will be line of English noncorrosive surgical needles, which are now widely used. A full stock is carried, so that shipment can be made the same day an order is received.

Gomco Surgical Mfg. Corp., Buffalo, N. Y. Booth 91. Complete lines of suction and pressure equipment will be exhibited, including a new mobile aspirator which affords strong, controlled suction, for floor use where large capacity and rugged durability are needed.

B. F. Goodrich Industrial Products Co., Akron, O. Booth 21. Exhibit will feature the complete line of surgeon's gloves, Koroseal hospital sheetings, and a wide variety of other rubber products for hospital use.

Guardian Chemical Corp., Long Island City, N. Y. Booth 67. Displayed will be Warexin for cold sterilization of instruments, rubber and plastic catheters and tubing, sutures, thermometers, heart lung machines, artificial kidneys, and other items and equipment. Warexin solutions are rapid, effective, nontoxic; articles may be used without rinsing.

Gudebrod Bros. Silk Co., Surgical Division, New York City. Booth 118. The complete line of Gudebrod nonabsorbable sutures will be shown, including silk sutures in black and color-coded with the Cerethermic finish, and cotton sutures in blue or color-coded. All are available in bulk or in the DriPak, ready for use.

Harold Supply Corp., New York City. Booth 74. Exhibited and demonstrated will be the Steriphane system, which utilizes hospitals' regular supply of reusable syringes and needles. The soiled needle container, for control of infection, as well as other O.R. and sterile supply room specialties will also be shown.

Hausted Mfg. Co., Medina, O. Booths 1, 2. Complete units for emergency and recovery rooms will be exhibited as well as a large selection of accessories including convertible and emergency OB table, portable examining table and stretcher, economy stretcher, and new pediatric stretcher with accessories. Also shown will be intermittent traction machine which compensates for movement of patient,

and new Invalaid chair for handling incapacitated patients.

Homer Higgs Associates, Inc., New York City. Booth 136. Featured will be Dennison wraps—specially processed paper developed to meet the specifications for wrapping hospital supplies prior to autoclaving. Also exhibited will be the Faultless Rubber Co.'s complete line of surgical rubber goods, featuring the new Epiderm surgeon's gloves.

Franklin C. Hollister Co., Chicago. Booth 123. Featured will be Ident-A-Band, for positive all-patient identification. Sealed on the wrist, it shows complete data for checking patient identity before surgery, and when administering blood. Ident - A - Band provides the nurse, surgeon, and others with positive proof of identity.

Hollywood Turban Products Co., Chicago. Booth 52. A new cap will be introduced at this meeting. Also featured will be Marvella nurse's surgery caps, designed for coolness, comfort, ease of fit on all heads, complete hair coverage, and perfect ventilation. Caps are available with elastic or drawstring back, in white or green muslin, white cotton shirting, or white nylon mesh.

Huntington Laboratories, Inc., Huntington, Ind. Booth 29. Featured will be San Pheno X to fight resistant staph; cleaners for skin or articles to combat cross-infection; conductive floor wax; Spal concentrate detergent; Germa-Medica liquid surgical soap; Hexa-Germ antiseptic skin detergent; hexachlorophene Baby-San; deodorants; cleaning chemicals; Hi Sine germicide; Marisan instrument cleaner; sanitation supplies; Formula #126 deodorant; and Bristolite wax.

Johnson & Johnson, New Brunswick, N. J. Booths 37, 38. Visitors are invited to the booth to meet the winner of the 1958 AORN Contest. A bulletin board will picture her activities. Also see the complete Patient-Ready line of sterile products, together with new adhesive tape cutters, and the revolutionary porous Elastikon tape.

Kansas City Assemblage Co., Kansas City, Mo. Booth 51. Exhibited will be the Padgett-Hood dermatome, manual and electro Model "B," and instruments used in plastic surgery.

The Lawton Co., New York City. Booth 63. Shown will be selected patterns of nontraumatic forceps for use in vascular and general surgery—an important advance in surgical instruments this year. Known as Wylie Clamps, these instruments will be available for the first time in a complete range of patterns. Also featured will be Lamb Wedge-Lok hand retractors, scientifically designed to eliminate fatigue.

Lehn & Fink Products Corp., New York City. Booth 92. Convention-goers are invited to visit the booth where technical representatives would like to help them with their cross-infection problems. Featured will be revolutionary new detergent/disinfectant Tergisyl, which may reduce labor costs as much as 47 percent. Free samples of Tergisyl and other Lehn & Fink products will be given.

The Lin Co., Clinton, Okla. Booth 26-A. Featured will be the sterile solution warmer, unique explosion-proof surgical heating unit, fully approved by Underwriters' Laboratories for hazardous locations, and proved as a low cost multi-purpose unit designed to save time and effort in operating rooms and wards. Heating element maintains constant temperature until the basin is removed. Adjustable thermostat keeps solution at fixed temperature indefinitely.

The MacBick Co., Cambridge, Mass. Booth 16. Display will include Pour-O-Vac flasks and closures for surgical fluids; MacBick solution warming cabinets; Urol-O-Vac flasks and closures for urological irrigating fluids; administration sets for closed cystoscopic, transurethral resection, and postoperative bladder irrigation; and Glove-O-Matic drier-powderers.

J. A. Majors Co., Dallas, Tex. Booth 135-A. The latest editions of all medical and nursing publishers' books will be on display for your examination and perusal: Alexander, *Care of Patient in Surgery;* Beal, *Manual of Recovery Room Care;* Berry and Kohn, *Operating Room Technic;* O'Neill, *Operating Room Technic;* Reddish, *Antiseptics and Sterilization;* Sadove, *Recovery Room;* St. Mary's Hospital, *Operating Room Technic;* and Yeager, *Operating Room Manual.*

Massillon Rubber Co., Massillon, O. Booth 106. Exhibited will be Matex surgeon's gloves featuring both rolled and color-banded wrists. New products shown will be the unique Marco Expenda-Gloves, one-use plastic gloves that are dispensed from a roll of paper, and Matex special pur-

(Continued on next page)

When POSTOPERATIVE OOZING Persists...

Efficacy of Antihemophilic Plasma in controlling the postoperative oozing that often occurs when patients have been massively transfused with banked blood has been reported by Howland.* He describes routine use of this specially processed plasma when oozing persists after closure of the wound. Fibrinolysis, he found, "usually responds dramatically" to its administration. Why this hemostatic efficiency? Because Antihemophilic Plasma is *fresh* plasma that has been rapidly processed to retain the labile clotting factors which are rapidly lost in banked blood. Hyland Antihemophilic Plasma (Irradiated, Dried) requires no grouping, typing or crossmatching. Just reconstitute with accompanying diluent and it is ready to administer. Five-year dating. Available in 3 sizes: 50 cc. with built-in filter for syringe administration; 100 cc. and 250 cc., each with administration set.

*Howland, W. S.: Cardiovascular and Clotting Disturbances during Massive Blood Replacement, Anesthesiology 19 (2): 140-152 (Mar.-Apr., '58).

HYLAND

Hyland Laboratories, Hyland
4501 Colorado Blvd., Los Angeles 39, Calif., 160 Lockwood Ave., Yonkers, N.Y.

DIACK

SINCE 1909

The Little Diack is the sign of Steam penetration *to the center* of an autoclaved bundle of dressings.

There is no substitute for perfect routine and a carefully trained autoclave operator—but unless Diacks are used this routine may be broken one day and infected patients can be the result.

For 46 years Diack Controls have been the choice of hospital people who know they can achieve proper sterilization of dressings *day in and day out* only through routine use of Diack sterilizer controls.

Research Laboratory of

SMITH & UNDERWOOD

Chemists

Sole Manufacturers of Diack Controls and Inform Controls

Royal Oak, Michigan

pose soap, designed for better cleansing and longer life of all latex products.

Mead Johnson & Co., Evansille, Ind. Booth 7. Displayed will be many new and special appliances for the collection and transfusion of blood and for the infusion of solutions, the Minimeter, the constantly closed system, the filter-then-pressure system, and other unique products and services designed for safety and convenience in parenteral therapy.

Meinecke & Co., New York City. Booth 113. Outstanding in the exhibit will be Haemo-Sol, the superlative cleaner for instruments and glassware, and Sterilwraps, disposable material for wrapping sterile packs. In addition, the Sterling hand brush dispenser, T.L.C. rubbing lotion, and conductive overshoes for operating-room use will be shown.

Metro Medical Distributors, Inc., Brooklyn, N.Y. Booth 80. Distributors in the U.S. and Canada of the products of Willy Ruesch, K. G., West Germany, since 1885 manufacturers of the famous Ruesch rubber catheters, rectal and Miller-Abbott tubes, and also of Amber (latex) balloon catheters, double lumen Carlens, and thermoplastic Rueschelit catheters.

V. Mueller & Co., Chicago. Booth 23. The Morch piston respirator and the new Kidd instrument rack will be features of the exhibit. The display will also include the Ben Venue ethylene oxide gas sterilizer, explosion-proof surgical pumps, and general instruments. Mueller representatives invite discussion of instrument problems.

National Cylinder Gas Co., Chicago. Booth 104. Various types of suction apparatus, the Handy resuscitator, wall and ceiling outlets, NCG deodorant, and emergency oxygen units will be demonstrated.

Ohio Chemical & Surgical Equipment Co., Madison, Wis. Booth 101. See three or four new sutures developed in cooperation with leading surgeons for special surgical procedures and technics. These are additions to the company's present extensive array of surgical sutures and needles. Demonstrations will also be conducted on Ohio Chemical Suture Laboratory's latest device to facilitate handling of sutures by operating-room nurses. Inspect sutures for their quality features, packing convenience, and the advantages of the direct service program.

O-R Products Co., Newton, Mass. Booth 62. Featured will be new developments for a complete hospital conductive program, highlighting the new O-R conductive shoe in colors, new conductive soles for regular duty shoes, disposable conductive strips, new O-R Ped-O-meter for shoe testing, and the new O-R disposable conductive bootie that keeps conductive shoes clean and reduces postoperative infection from dirty shoes to a minimum.

Orthopedic Equipment Co., Bourbon, Ind. Booth 56. Exhibited will be the No. 464 improved screw driver, which can be used with any type of bone screw, and which greatly facilitates the fixing of screws during surgical operations. Closing or opening quick-action lever recessed in the handle fixes or releases screw from the shaped recess in the end of the tubular shaft.

Parke, Davis & Co., Detroit, Mich. Booths 119, 120. Representatives will be available to discuss products of special interest to O.R. personnel, such as Surital sodium, Chloromycetin intramuscular and intravenous, and parenteral Dilantin. Benadryl, Carbrital, penicillin S-R and S-R-D, Thrombin topical, Oxycel, and surgical dressings will also be featured.

The Pelton & Crane Co., Charlotte, N.C. Booth 122. Those who have complaints from surgeons about hinged instruments sticking; those who have difficulty removing tissue and bone matter from serrations on instruments; those whose hospitals are troubled with pyrogens should investigate the portable, low-cost ultrasonic washer and dryer on display at this booth.

Perry Rubber Co., Massillon, O. Booth 8. Displayed will be the new, superthin, disposable latex surgeon's gloves, prepackaged, prepowdered, ready for the autoclave, and priced lower than average cost for processing and use. Also shown will be a new package of a single disposable latex glove for use in proctological and other examinations.

Personal Products Corp., Milltown, N. J. Booth 128-A. Professional uses for Modess napkins and tampons will be highlighted.

Pharmaseal Laboratories, Glendale, Calif. Booth 128. Exhibited will be a complete line of high-quality, expendable plastic intubation equipment,

as well as the Pharmaseal, Sigmol, oil retention, and dry-mix enemas.

Phelan Manufacturing Corp., Minneapolis. Booth 55. Featured will be the Helix reservoir blood oxygenator, Straddle instrument table, Add-A-Unit step stand, ceiling-mounted I.V. bottle holder, and new ceiling-mounted Valentine irrigating bottle holder, which avoids hazards of conventional mounting, and is safe and easy to operate.

George P. Pilling & Son Co., Philadelphia. Booth 58. Personnel in attendance at the booth will be prepared to discuss mechanical details and design of the various Pilling-made surgical instrument specialties. A specially selected group of the newest instruments will be shown.

Pioneer Rubber Co., Willard, O. Booth 73. The entire line of the company's long-lasting medical gloves will be exhibited, including: Rollpruf surgical gloves, with flat banded wrists; Quixam examination gloves, one of which will fit either hand; Nimble Fingers, tissue-thin utility gloves; and many other types and styles to fill every hospital requirement. All Pioneer latex gloves exceed Federal Specification ZZ-G-421a.

Pratt Hospital Equipment Mfg. Co., Los Angeles. Booth 129. Exhibited will be the RS-100 recovery room stretcher, in use in most large Pacific Coast hospitals; the PS-600 recovery room and polio suction machine, which is two suction machines in one cabinet; and many other exclusive items of recovery-room and surgery equipment.

Professional Tape Co., Inc., Riverside, Ill. Booth 94. Exhibited will be Time autoclave labels with TSI (Time sterile indicator)—a scientific development designed to take the guesswork out of autoclaving. The word "sterile" appears on the Time autoclave label only after it has been in the autoclave for a complete standard sterilization cycle. Labels seal, identify, tell condition, number, and size of articles, and eliminate pencil mark mistakes. New 16-page general catalog will also be distributed.

Randall Faichney Corp., Boston. Booth 15. A new hospital tested and approved type of urinary drainage set will be introduced. Packaged sterile, this disposable item is designed for narrow neck receptacles. Also on display will be our new transfusion outfit with an "in line filter" and the regular line of precision hypodermic needles, syringes, and specialties.

Richards Mfg. Co., Memphis, Tenn. Booth 17. The new Richards pneumatic tourniquet, successor to the Campbell-Boyd, will be shown, as well as the Boyes-Parker hand surgery table with special equipment for saving operating-room time. Fine cutting instruments, portable cassette holder, pin cutters, and a complete showing of Smo stainless implants will be exhibited.

Ritter Co., Inc., Rochester, N. Y. Booth 26. Exhibited will be an innovation in surgical lighting, featuring dust dispersal facilities for asepsis, elimination of counterweight, other factors. Change in light pattern size as well as beam direction is accomplished by surgeon or by nurse through fully remote control. L-F Bovies and other related equipment will also be displayed.

Roche Laboratories, Nutley, N. J. Booth 79. Products of special interest to operating room nurses will be featured, including synthetic narcotic, Levo-Dromoran, for relief of severe pain; Nisentil, rapid-acting, synthetic narcotic analgesic; and Arfonad, rapid, short-acting vasopressor.

Roehr Products Co., Inc., Waterbury, Conn. Booth 95. Exhibited will be the Monoject line of disposable needles: Monoject 150—bulk pack, luer lock hypodermic needles; Monoject 200—sterile and individually packed luer lock hypodermic needles; Monoject 210—sterile, individually packed blood collection needles; and Monoject 220—sterile, disposable spinal needles.

Will Ross, Inc., Milwaukee, Wis. Booth 48. Exhibited will be Arex individual lubricating jelly packages; Arex cleanser for instruments, glass, and rubber articles; White Knight glove wrappers; disposable surgeon's gloves; Kenwood memo obstetrical towelettes for perineal care; and disposable caps and masks.

Ruby Products Co., Inc., Milwaukee, Wis. Booths 96, 97. Displayed will be prepackaged disposable surgical draperies for obstetrical and gynecological surgery as well as other surgical packs, and a complete line of packaging media for sterile parts and supplies. Special emphasis will be given to the prepackaged, hospital customized, disposable packs for a variety of surgical procedures.

(Continued on next page)

IT'S FOOT OPERATED
IT'S ON CASTERS
IT'S ERKA

NEW ERKA O.R. STANDFAST SPHYGMOMANOMETER

Now both hands are free— when taking readings with world famous ERKA'S O.R. Standfast Sphygmomanometer. Pressure and release is fully controlled by twin foot pedals. 300mm scale is angled upwards to facilitate accurate readings while sitting or standing.

Tubing and cuff store neatly in side compartment. Tilting unit backwards places the casters in contact with the floor, providing easy movement.

Full ERKA Guarantee includes lifetime replacement of glass tube.

NOW AVAILABLE AT YOUR SURGICAL SUPPLY HOUSE

For complete information on O.R. "Standfast" and other ERKA Blood Pressure Apparatus, write:

Miltex

E. MILTENBERG, INC.
43 GREAT JONES ST.
NEW YORK 12. N. Y.

Dennis R. Scanlan, Jr., Inc., St. Paul, Minn. Booth 28. The complete line of Scanlan Swedish stainless steel surgical instruments, known for their quality and design, will be displayed. The instruments are made in Sweden at a factory established in 1808.

Chas. A. Schmidt Surgical Instrument Co., St. Louis. Booth 135. Highlighted in the display of a complete line of orthopedic instruments will be Lottes intramedullary nails and accessories, and the Vitallium prosthesis. Also shown will be a comprehensive array of domestic and imported instruments for general surgery, featuring the Stille line.

The Seamless Rubber Co., New Haven, Conn. Booths 11, 12. Kolor-sized surgeon's gloves will be featured, together with Pro-Cap adhesive tape with new improved tack. Ezon glove powder will also be highlighted, as well as the complete line of surgical dressings.

Shampaine Co., St. Louis. Booths 89, 90. Featured will be the S-1501 Surg-a-matic major operating table, years ahead in design and engineering, with push button shift, motorized or manual height adjustment, full head end control, and other features for modern surgical technics. Friction lock clamps simplify and speed attaching operating table accessories.

Sierra Engineering Co., Sierra Madre, Calif. Booth 35. Professional products of particular interest to operating-room personnel will be exhibited and discussed with booth visitors.

J. Sklar Mfg. Co., Long Island City, N. Y. Booth 127. Displayed will be many instruments of recent development, including a new finger bandage scissors, coronary sinus sucker, pediatric suction tube, large-size Satinsky clamp, and new intestinal instruments featuring Kapp-Beck serrations.

Smith & Underwood, Royal Oak, Mich. Booth 86. The new Inform control for indicating sterilization for infant formula in terminal autoclaving will be exhibited, along with the standard Diack control for use in autoclaving surgical goods. Samples of both controls will be available, and souvenirs will be given.

Snowden-Pencer Corp., Los Gatos, Calif. Booth 53. Surgical Instrument-Milk, the new non-oily, non-sticky, rust-prohibiting lubricant for all surgical instruments, will be exhibited. Saves time, prevents rusting, keeps box locks free, reduces instrument repair and replacement costs. Also shown will be a complete selection of Ochsner Diamond-Jaw needle holders and Diamond-Edge scissors with gold-plated ring handles for immediate identification.

E. R. Squibb & Sons, New York City. Booths 65, 66. Presented will be up-to-date information on development of new therapeutic agents for prevention and treatment of disease. Results of research will be available in new products or improvements in products already marketed.

Stanley Supply Co., Inc., Dallas, Tex. Booth 76. The Stanvelope system for putting up sterile needles and syringes will be featured. Also shown will be disposable conductive booties for contaminated cases; Stantape, printed autoclave tape; and Patapar paper for sterile packs.

Storz Instrument Co., St. Louis. Booth 19. Latest developments in surgical instruments and equipment for the specialties of eye, ear, nose, throat, neurosurgery, and plastic and thoracic surgery will be displayed. A representative will be happy to answer any questions concerning the maintenance and sterilization of the company's instruments, and to accept requests for catalogs.

Tailby-Nason Co., Inc., New York City. Booth 131. Betadine antiseptic, a new iodine complex devoid of iodine burn, will be featured. It is nonirritating and film-forming, for use as topical antiseptic and therapeutic bactericide. Available in solution and aerosol spray, Betadine exhibits all of iodine's potent microbicidal activity, and is especially effective against antibiotic-resistant *Staphylococcus aureus.*

United Surgical Supplies Co., Inc., Port Chester, N. Y. Booth 115. Full line of Sanger-Taylor aortic and blood vessel grafts in both dacron-nylon and Teflon material will be demonstrated. The Bongort P-O drainage bag, the "saver of dressings," will be shown, and samples will be available. In addition, many specialties will be displayed, and visitors may register for the new specialty catalog.

Vestal, Inc., St. Louis. Booth 69. The prevention of staphylococcal infection among hospital patients, through the use of Vestal products, will be described. Products featured will be Septisol antiseptic soap, Staphene germicide-disinfectant, and Vesphene germicidal-detergent.

Edward Weck & Co., Inc., Brooklyn, N. Y. Booth 108. Exhibited will be a completely new system for handling syringes and needles; assembly-line processing for central service; Wexteel, the new name for quality in surgical scissors; and Bulldog, the new name for quality in needle holders. See the scissors-testing machine in action.

West Chemical Products, Inc., Long Island City, N. Y. Booth 33. Wescodyne, detergent-germicide for hospital use containing "tamed iodine" will be exhibited. Nontoxic, nonstaining, and nonirritating to the skin when used as directed, Wescodyne contains a built in safety feature; in use, its amber color guarantees the presence of germicidal activity. In addition to its uses for environmental sanitation, Wescodyne, which is nonselective in its action against pathogens, has application in hospital isolation technics and procedures.

Wilson Rubber Co., division of Becton, Dickinson and Co., Rutherford, N. J. Booth 42. Featured will be the new Rapak surgeon's glove, a prepackaged, ready-to-sterilize, curved finger glove. Also featured will be the new Brown Mill surgeon's glove, other surgical rubber products.

Winthrop Laboratories, Inc., New York City. Booth 36. Featured will be pHisoHex, soap-free, sudsing, creamy, antibacterial detergent for use on the skin, scalp, and certain mucous membranes. Used routinely and exclusively, it develops on the skin a cumulative film possessing prophylactic and therapeutic properties. Fully active in hard or cold water, and under acid or alkaline conditions, pHisoHex is a rapid cleaner, and a superior degerming agent.

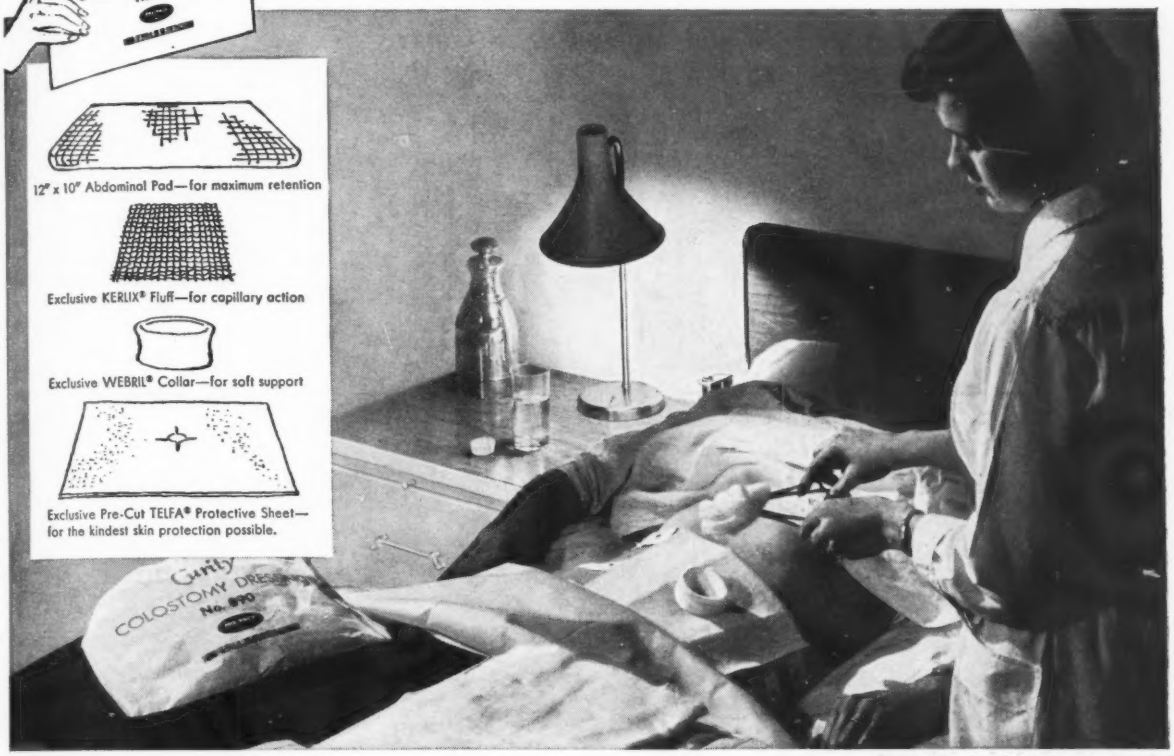
Wright Mfg. Co., Memphis, Tenn. Booth 138. Examples of the company's line of orthopedic equipment will be displayed. Representatives will discuss technics of use and latest developments.

Zimmer Mfg. Co., Warsaw, Ind. Booth 114. Featured will be the latest appliances and instruments for orthopedic surgery, together with a discussion of the technics covering their use. Lounge chairs, providing an opportunity to rest a moment will also be a part of the booth.

THE MOST EFFICIENT COLOSTOMY DRESSING EVER MADE—

NEWEST EXAMPLE OF CURITY LEADERSHIP IN PRE-PACKAGED DRESSINGS

12" x 10" Abdominal Pad—for maximum retention
Exclusive KERLIX® Fluff—for capillary action
Exclusive WEBRIL® Collar—for soft support
Exclusive Pre-Cut TELFA® Protective Sheet—for the kindest skin protection possible.



Hospital Furniture by the Simmons Company

Curity® Pre-Pack—The modern way to efficient dressings technique

Easily assembled, neatly disposed of—the latest in Curity's Pre-Pack Hospital Dressings is designed especially for a colostomy. Four well-fitted units that take the waste and mess out of "improvising."

Curity Pre-Pack dressings more than pay for themselves in savings of time, materials and costly hand labor. Counting, folding, labeling, wrapping—they're all done with the quality and unfailing consistency that only precision-made machines can maintain.

Keep in touch with your Curity representative for complete data on the latest in Pre-Pack Hospital Dressings.

Why not take advantage of all these labor-saving Curity Pre-Packs?

- Cover Sponges (641)
- KOTEX* Maternity Pads with Wondersoft*
  - Pre-Pack 12's (650)
  - Pre-Pack 1's (659)
  - 1's with 4 Curity Cotton Balls (663)
- TELFA Non-Adherent Sponge-Pad (196)
- TELFA Non-Adherent Strip (747)
- Colostomy Dressing (890)
- Heavy Drainage Dressing (893)
- Abdominal Pad 10" x 8" (109)
- Abdominal Pad 7½" x 8" (179)
- KERLIX Roll (73)

PRE-PACK UNIT

Curity®
HOSPITAL DRESSINGS
Bauer & Black
DIVISION OF THE KENDALL COMPANY

*Reg. T.M. of Kimberly-Clark Corp.

For additional information on products advertised, circle number on reply card opposite page 152. 127

DEKNATEL NEEDLED SILK

DRY PAK

in transparent

DEKNATEL PLASTIC PAK

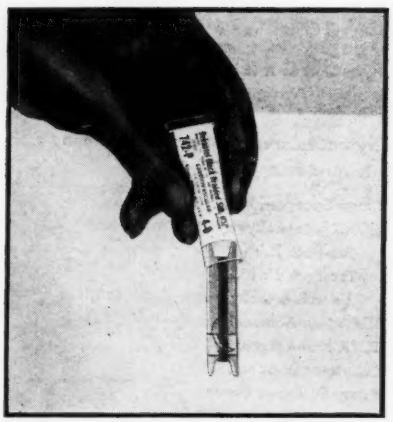
FOOLPROOF SAFETY

- **Transparent Deknatel Plastic Pak is sterilized in the solution you have known and relied upon: FORMALDEHYDE.**
- **Each Deknatel Pak is subjected to an exacting test for leakage.**
- **There is no leakage problem with the Deknatel Pak. Prove it to yourself:**

Deknatel Plastic Pak is stored in a jar solution containing fluorescein dye. Should a Pak develop a leak, detection is immediate and foolproof: Pak would contain colored storage fluid. ONLY DEKNATEL gives you this visual protection!

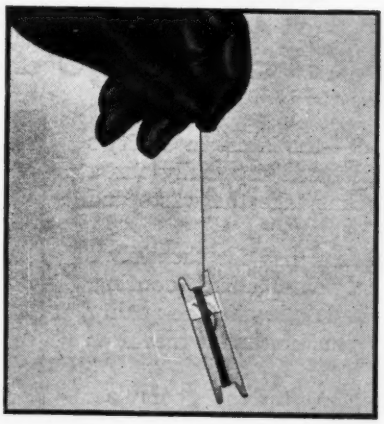
FAST, SIMPLE HANDLING

SLIDE OUT



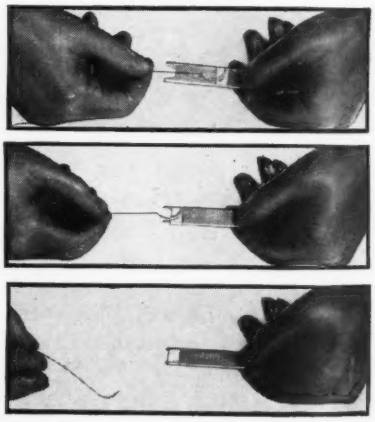
Invert reel and press sides. Instruments not needed for removal — reel drops freely from cut Pak.

ONE-HAND UNWIND



Hold suture end. Metal reel unwinds by its own weight.

SLIDE OFF



Needle is automatically freed from its protective metal tab. No instruments required.

For samples, write

J. A. Deknatel & Son, Inc.

96-24 222 Street, Queens Village 29, New York

New Surgical Dressing Technic Helps Hahnemann Combat Staph

Central Supply

By Cecilia D. Yastremski, R.N.*

• With the daily newspapers full of news of hospital staphylococcal infection outbreaks and the technical journals crying for a return to the days of more stringent asepsis and antiseptic technics, Philadelphia's 72-year-old Hahnemann Hospital has re-evaluated its surgical dressing technic and come up with a working, efficient, acceptable method.

This technic is but one of the many methods Hahnemann is employing to combat staphylococcal infection.

Floor nurses had always carried the heaviest load in the dressing of surgical wounds at our hospital. To relieve the nurses and also insure that someone was available at all times, an experiment was decided upon utilizing specially trained practical nurses as part of a dressing team under the supervision of a professional nurse. This team would be trained by the central supply supervisor, a professional nurse, and would operate exclusively from her department.

Such a team, it was thought, would appreciably prevent cross-contamination and control staphylococcal infection cases, and would emphasize, to both doctors and nurses, the necessity for careful technic.

A program was instituted that taught participating practical nurses the proper technic for gloving and gowning and for opening prepacked and presterilized supplies and sterile instrument packs.

For three weeks, on-the-spot seminars were held, with the practical nurses making surgical dressing rounds with the residents and the central supply supervisor. In classes, the use of instruments and the proper technics for sterilizing them were taught.

Then, for another two weeks, the practical nurses were taught the technics of dressing under the close supervision of an R.N.—the central supply supervisor.

Floor nurses also participated in the final training, checking ability and sterile technic.

The wheeled carriers used are assembled by the central supply department. Sterile equipment includes caps and masks, gowns, gloves, gauze, towels, combine pads, Kling bandages, rolled bandages, Penrose drains, knife handle, and blade.

Four packs are made up for dressings. The major pack includes thumb forceps, clip remover, hemostats, two cotton balls, and two applicators. The sterile chest pack includes a Kelly and hemostats. Sterile scissors and a sterile wire-cutter are each wrapped separately.

The instruments used are all numbered, according to pack, and the practical nurse is responsible for the equipment and instruments used in her cart.

In addition to the items mentioned above, the cart also holds alcohol cotton balls, peroxide cotton balls, adhesive tape, Montgomery straps, tincture of merthiolate, forceps in 70 percent alcohol, Scotch tape, procaine, culture tubes, silver nitrate sticks, tincture of benzoin, surgical dressings, waxed paper bags, shopping bags, sterile distilled water, an irrigation set, safety pins, Vaseline gauze, and iodoform gauze.

There are three surgical floors which utilize the cart. It is used for surgical rounds at 7:30 a.m. for the ward surgical floor and is on call for the other two floors, which house chest surgery patients.

(Continued on next page)

Wheeled carrier is assembled by central supply department, contains numbered instruments, dressing medications, and sterile equipment including caps and gowns.

*Central supply supervisor, Hahnemann Hospital, Philadelphia.

LOOK . . . NO HANDS
with
HAEMO-SOL
the original "NO SCRUB" cleaner

For *chemically clean* surgical instruments and glassware, just SOAK . . . RINSE!

- **CLEANS FAST,** completely. No scrubbing, no hand work.
- **RINSES EASILY** . . . leaves no residue.
- **SAFE** . . . won't rust metal or etch glass . . . harmless to plastics.
- **ECONOMICAL** . . . only ⅓ oz. to 1 oz. per gallon of water, and *it's reusable.*

NEW FOR PRESSURE WASHERS

HAEMO-SOL "N.S." non-sudsing compound is scientifically formulated for pressure washers.

- Extremely fast acting. Cleans efficiently even in machines with quick wash cycles.
- No interfering suds or foam with any type of soil.
- Rinses completely. No residue.
- Economical . . . 100% effective in concentrations of 1 oz. per 5 gals. of water.

Haemo-Sol is packed in hospital blue and white, all-metal 5-lb. containers. Cost? 12 cans only $5.40 each, 6 cans —$6.08 each, 1-5 cans—$6.75 each.

Write for literature and FREE Samples. Be sure to specify regular HAEMO-SOL or HAEMO-SOL "N.S."

Meinecke & COMPANY, INC.
Over 65 years of continuous service to the hospitals of America
211 Varick St. • New York 14
Branches in Los Angeles, Dallas, Chicago & Columbia, S. C.

Above: Doctor changes surgical dressing on patient with practical nurse assisting him. Previously, he donned sterile cap, gown, mask, and two pairs of gloves. Practical nurse has prepared patient, placing face towel over his nose and mouth. She has also placed two waxed paper bags on bed.

Below: After removing dirty dressing, the doctor drops it into waxed paper bag. He then removes outer pair of gloves and places them in the second bag. After wound has been dressed, the instruments and the doctor's gown and second pair of gloves are also placed in the second bag. The first bag is burned; the second is returned to central supply where its contents are autoclaved and washed.

CENTRAL SUPPLY continued

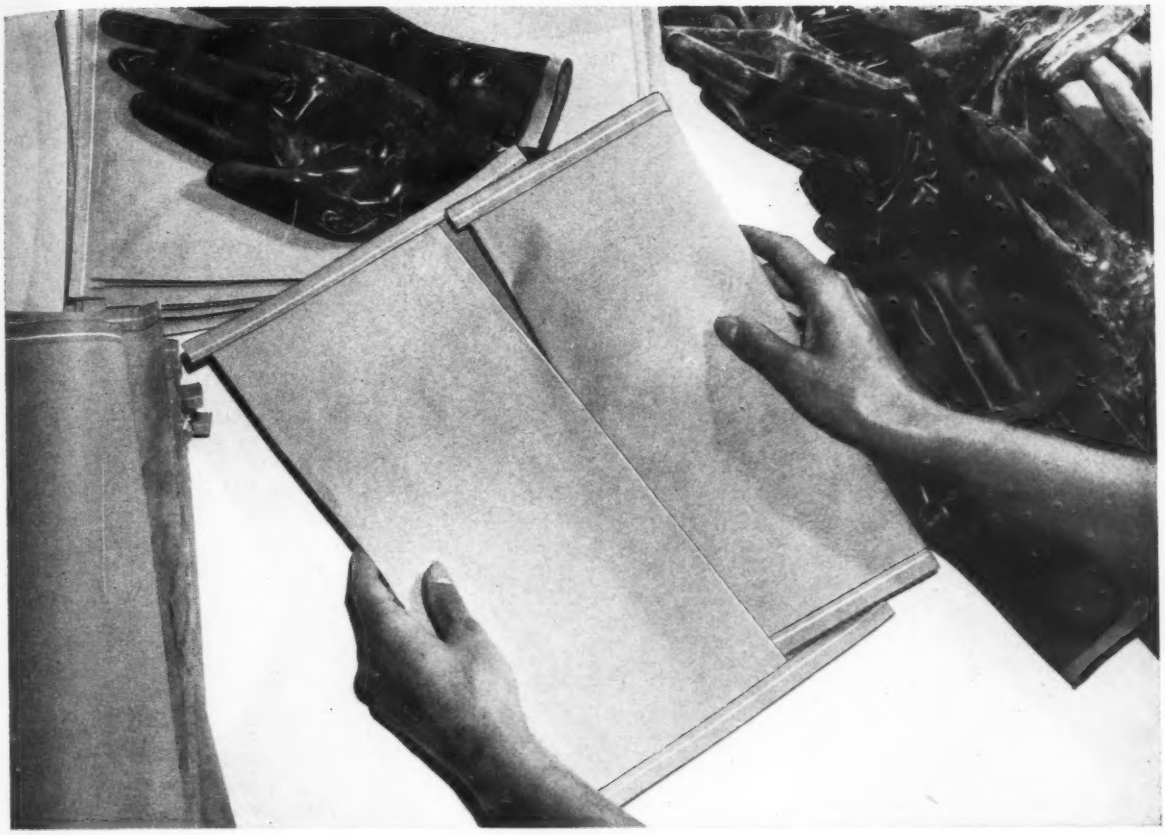
Dressing information has already been supplied by the doctors making 7:00 a.m. rounds. This information facilitates use of the cart.

At the start of the rounds, the doctor puts on cap, mask, gown, and two pairs of gloves. He retains the same cap and mask throughout the rounds. The practical nurse, wearing cap and mask, assists the doctor. She then gets the patient ready, sets up the screen (if necessary), lowers the bedspread and sheet, puts a face towel over the patient's nose and mouth, and places two paper bags on the bed, one for dirty dressings, the other for dirty instruments and gloves.

The instrument pack is then opened on the bed, and gauze and alcohol cotton balls are placed on the cover with the instruments.

The doctor on dressing duty then removes the dirty dressing

(Continued on page 132)



These are Dennison Wraps

WHAT ARE THEY? THE MOST EFFICIENT AND ECONOMICAL AUTOCLAVE WRAPPERS

What are their advantages?

Comparative tests have proved them to be superior in every respect*

- superior steam penetration
- maximum shelf life
- easier wrapping — exclusive two-way stretch
- no cutting, sewing, mending, laundering
- reusable — quick and easy to inspect
- strong — wet or dry
- easy to stock-pile sterilized supplies
- neater, more compact bundles save storage space

*data sent on request

Dennison Wraps for autoclaving are made from a special kraft, treated and processed to combine strength and flexibility. They come in a wide variety of sizes — including glove envelopes and cases as illustrated above. They accommodate supplies commonly wrapped for use in operating rooms, delivery rooms, laboratories and all patient areas.

—Why don't you try them at our expense?—

Dennison, Dept. L-171,
Framingham, Massachusetts
Please send me samples of Dennison Wraps.

Name.....

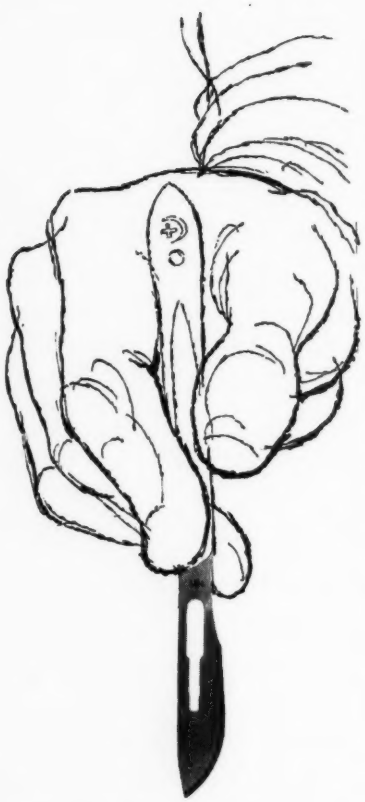
Title.....

Hospital.....

City.....*State*.....

Dennison Wraps
FOR AUTOCLAVING

COMBINING THE QUALITIES OF CLOTH WITH THE ECONOMY OF PAPER



satisfactory to surgeon and budget

The surgical staff's most exacting demands are satisfied by the keener edge, better balance and greater weight of Crescent Blades.

The budget benefits by savings of up to one-third made possible by Crescent Blades.

TRY before you BUY. Send for free sample.

Crescent Surgical Sales Co., Inc.
48-41 Van Dam Street
Long Island City, New York

Crescent

surgical blades and handles

CENTRAL SUPPLY

(Continued from page 130)

from the patient and places it in the waxed paper bag. He then removes the outer pair of the gloves he donned previously, and places them in the second bag. He cleanses the wound area with 70 percent alcohol and dresses the wound.

The soiled instruments are wrapped in the cover and placed in the second bag with the gloves.

The doctor then removes the gown and the second pair of gloves and places these in the second bag. This bag is then put into the shopping bag and returned to the central supply department. The bag and its contents are autoclaved before the gloves and instruments are removed and washed.

The first bag, containing the dirty dressings, is placed in a special container on the floor. Immediately after the dressing rounds, this container is emptied into the floor trash chute which leads directly to the incinerator. There, the material is burned at once.

The doctor then washes his hands and proceeds to the next patient. The same technic is repeated.

The dressing carrier or cart never goes into a patient's room or near a patient's bed.

Patients in isolation are redressed using the same technic, except that the cap, gown, and mask are placed in the isolation bag within the patient's unit and disposed of by the accepted method at the close of each 8-hour tour of duty. The gloves and instruments are placed in waxed paper bags—two are used for added protection—then in a shopping bag, and returned to the central supply department for autoclaving before cleaning.

Central supply personnel do not enter the isolated patient's room. All supplies are passed in to the doctor as needed.

Hahnemann Hospital's infection-control record is good. We believe this record can be ascribed to the tightening of technic in all areas, particularly the operating room and the surgical patients' floors.

This improved surgical dressing technic is part of the redisciplining of the hospital's entire program. Although it is somewhat elaborate and time-consuming, we believe that its significance becomes apparent when one considers that, at the time of writing,* not a single case of cross-infection has been reported on any of the three surgical floors since the experiment began.

*October, 1958.

International Authorities to Discuss Resistant Infections

A worldwide picture of the clinical problems of bacterial resistance and methods of dealing with them will be presented at the International Colloquium on Resistant Infections, to be held in New York City, November 20 and 21.

The conference is being sponsored jointly by the United States Committee, World Medical Association, and Eaton Laboratories, Norwich, N.Y.

Particular emphasis will be placed on the control of staphylococcal infections in hospitals. The role of drugs, both as contributors to the development of resistance, and as a means of helping to solve the problem, and the need for more rigid aseptic technics to control the spread of infectious organisms will be discussed.

All the medical disciplines concerned with the resistance problem will be covered in conference sections. Section chairmen will be: Harry A. Feldman, M.D., professor and chairman, department of preventive medicine, State University of New York College of Medicine, Syracuse; Austin I. Dodson, Sr., M.D., professor and chairman, department of urology, Medical College of Virginia, Richmond; Arthur J. Vorwald, M.D., professor and chairman, department of industrial medicine and hygiene, Wayne State University College of Medicine, Detroit; Truman G. Blocker, Jr., M.D., professor of plastic and maxillofacial surgery, University of Texas Medical Branch, Galveston; and Carl W. Walter, M.D., associate clinical professor of surgery, Harvard Medical School, Boston.

B-D HYPAK
NOW...TAKE YOUR CHOICE

B-D OFFERS

"DISPOSABLES"

DESIGNED FOR ONE-TIME-USE

B-D HYPAK®

STERILE DISPOSABLE GLASS SYRINGE-NEEDLE COMBINATION

ALL GLASS BARREL—from vial to injection, your medication is safe in clear, Resistance glass—the proven material. **B-D CONTROLLED**—sterile, pyrogen-free, nontoxic. **NEW, SHARP NEEDLE POINT**—greater patient comfort.

B-D YALE®

STERILE DISPOSABLE HYPODERMIC NEEDLE

TRULY DISPOSABLE—color-coded, inert plastic hub* will not withstand conventional resterilization. **STERILE, PYROGEN-FREE, NONTOXIC**—B-D Controlled. **SAVES LABOR**—no after-use handling. **NEWLY DESIGNED POINT**—smooth penetration every time. Fits all Luer-Lok® and Luer-Slip syringes.

MANUFACTURED, STERILIZED AND CONTROLLED By B-D

B-D DISCARDIT PRODUCTS

*AUTIAN, J., AND BREWER, J. H.: AM. J. HOSP. PHARM. 15:313, 1958.

...OR "REUSABLES"

FOR MAXIMUM IN-USE ECONOMY

B-D MULTIFIT®
INTERCHANGEABLE SYRINGE WITH CLEAR GLASS BARREL

REDUCED BREAKAGE—barrel of clear, Resistance glass unweakened by grinding.
EASILY AND QUICKLY ASSEMBLED—no tedious matching of parts.
LOWER REPLACEMENT COSTS—every plunger fits every barrel.
CONTROLLED FIT—"backflow" eliminated.

B-D YALE
STAINLESS HYPODERMIC NEEDLES

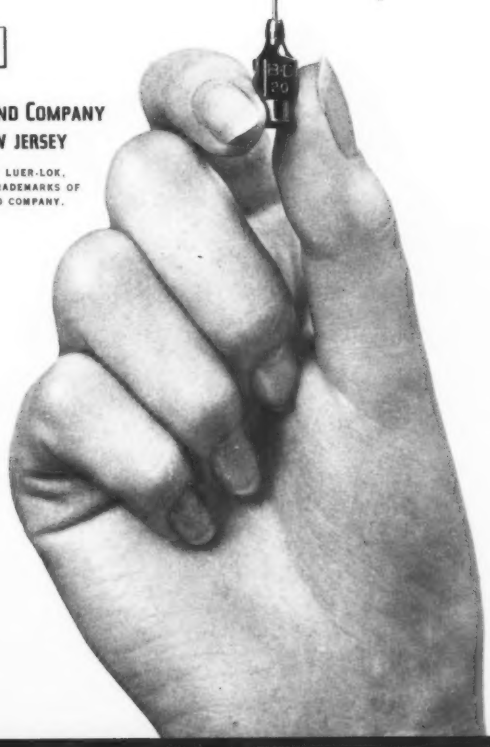
RUST-RESISTANT throughout—**STIFF** enough to pierce tissues easily—**FLEXIBLE** enough to bend without breaking—**HARD** enough to hold a sharp point—**TOUGH** enough to assure long use.

STANDARD OF THE MEDICAL PROFESSION SINCE 1897

B-D

BECTON, DICKINSON AND COMPANY
RUTHERFORD, NEW JERSEY

B-D, DISCARDIT, HYPAK, LUER-LOK, MULTIFIT AND YALE ARE TRADEMARKS OF BECTON, DICKINSON AND COMPANY.

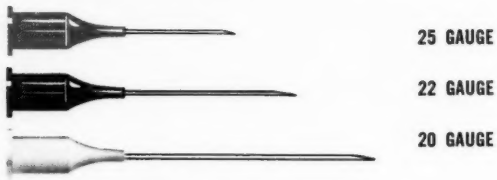


DISCARDIT

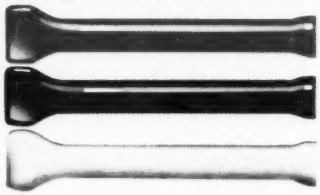
HYPODERMIC EQUIPMENT

COLOR-CODED for easy identification

YALE
Sterile Disposable Needle



HYPAK Sterile Disposable GLASS
Syringe-Needle Combination



PACKAGED for hospital convenience

YALE STERILE DISPOSABLE NEEDLES—for all B-D Luer-Lok and Luer-Slip Syringes

Catalog No.	Gauge	Color Code
HSYN	25 Gauge x 5/8"	(Blue)
HSYN	22 Gauge x 1"	(Black)
HSYN	22 Gauge x 1½"	(Black)
HSYN	20 Gauge x 1"	(Yellow)
HSYN	20 Gauge x 1½"	(Yellow)

100 needles (20 strips of 5) in sturdy package with handy slide-off sleeve for disposing of used needles. Shelf package: 1000 needles. Case: 5 shelf packages (5000 needles)

HYPAK STERILE DISPOSABLE GLASS SYRINGE-NEEDLE COMBINATION

A702	2 cc. with 25 x 5/8" needle	(Blue)
A702	2 cc. with 22 x 1" needle	(Black)
A702	2 cc. with 22 x 1½" needle	(Black)
A702	2 cc. with 20 x 1½" needle	(Yellow)

Individual unit in sealed polyethylene bag. 20 units per box. Shelf package: 25 boxes (500 units). Case: 2 shelf packages (1000 units).

B-D CONTROLLED your assurance of sterility

On all sterile, disposable DISCARDIT products, B-D supplements federal sterility controls by introducing with each product lot undergoing sterilization, red-marked products contaminated with organisms known to be resistant to the sterilizing agent. B-D passes production lots only if post-sterilization tests establish the sterility of both regular product samples and the extra red-marked control samples.

B-D **BECTON, DICKINSON AND COMPANY · RUTHERFORD, NEW JERSEY**

in Canada BECTON, DICKINSON & CO., CANADA, LTD., TORONTO 10, ONTARIO

B-D, DISCARDIT, HYPAK, LUER-LOK, MULTIFIT AND YALE ARE TRADEMARKS OF BECTON, DICKINSON AND COMPANY.

©1958, BECTON, DICKINSON AND COMPANY

PRINTED IN U.S.A.

55458

TRADE TOPICS . . .

Ethicon Names Two New Vice-Presidents

Ethicon, Inc., has named Edward Henrys vice-president of advertising, and T. W. Eckels vice-president of sales.

Mr. Eckels

Mr. Henrys

Mr. Henrys joined Ethicon in 1953 as advertising manager. Previously he had headed his own advertising group and had worked for several advertising agencies.

Mr. Eckels began with Ethicon in 1945 as a New York sales representative. He has held the positions of sales training director, Midwest divisional manager, field sales manager, and director of sales for the company.

Regan Acquires Dispenser Manufacturing, Sales Rights

Regan Industries, Inc., has acquired manufacturing and sales rights for the Corinth Finger-Tip fluid dispenser from Corinth Instrument Co. Regan is also manufacturing an umbrella-shield nozzle as accessory equipment for the dispenser. Sales will be through distributors and sales representatives.

SchenLabs Sponsors Clinical Section in Student Journal

SchenLabs Pharmaceuticals, Inc., in November, will begin sponsorship of a monthly clinical-pathological conference section in *The New Physician*, official journal of the Student American Medical Association.

Each section will consist of a verbatim transcript of a physicians' clinical conference at a major medical center. A complete diagnosis will be presented followed by a discussion and outline of treatment.

Reprints of the transcripts will be distributed to other practicing physicians also.

William L. Estes, Jr., M.D., Bethlehem, Pa., president, American College of Surgeons (r.), receives Cine Clinic plaque from R. C. Swain, M.D., vice-president, American Cyanamid Co. Plaques were awarded by the company's Surgical Products Division to 28 surgeons who participated in and helped prepare films for the Cine Clinic, sponsored by the company at the annual ACS congress, held in Chicago in October. The movies will be shown to hospital personnel through the firm's Surgical Film Library.

Abbott Appoints New Distribution Manager

Ralph C. Dart has been appointed manager, distribution department, sales division, Abbott Laboratories. Mr. Dart, who has been with the firm 30 years, previously was associate distribution manager.

Floyd K. Thayer, vice-president and director of chemical sales at Abbott, has been cited as "Marketing Man of the Year" by the Chicago chapter of the American Marketing Association.

Mr. Thayer, an employe since 1920, was honored at the chapter's award dinner in October.

Bristol Laboratories, Inc., Makes Six Appointments

Amel R. Menotti, Ph.D., vice-president, Bristol Laboratories, Inc., has been named scientific director and will supervise the company's medical and research divisions.

Other Bristol appointments include: H. Leo Dickison, Ph.D., director of laboratories; Joseph J. Lein, assistant director of laboratories; and Merle H. Pindell, Ph.D., director, pharmacologic research.

Victor T. Johnson has been named vice-president and director of marketing, succeeding Richard A. Anderson.

Also at Bristol, Roland H. Noel has been appointed director, sales promotion.

Mead Johnson Names Two New Development Directors

Mr. Mulle

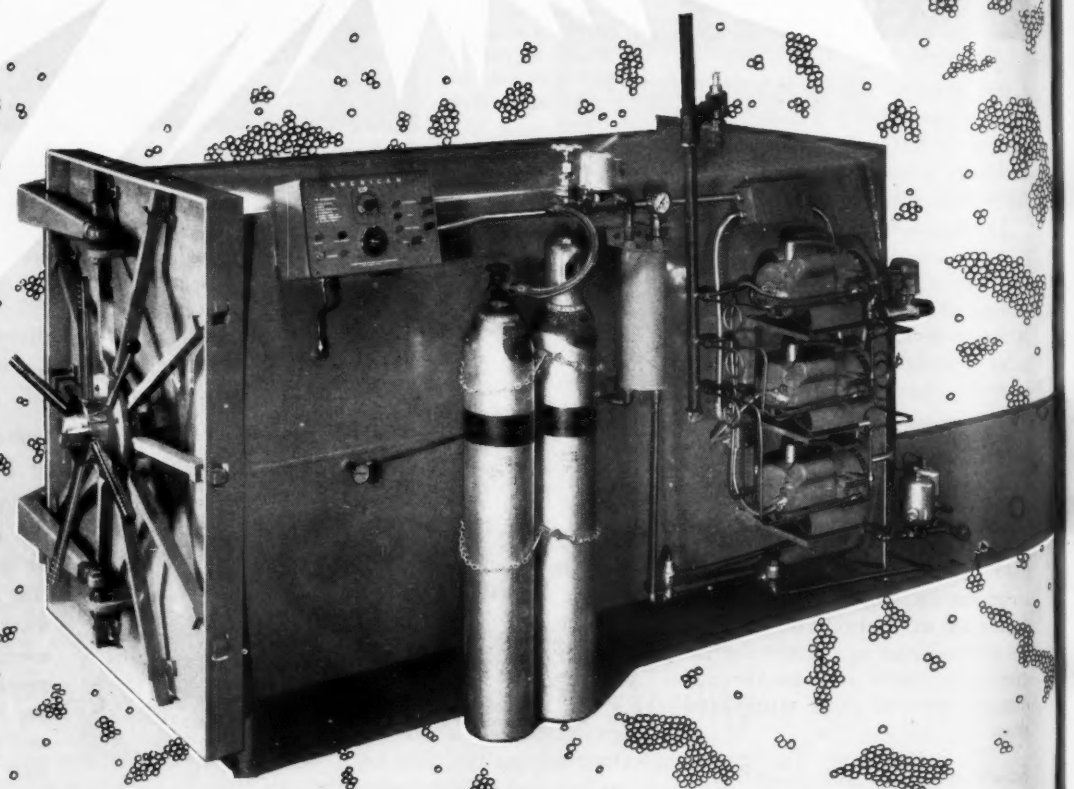
A. Thomas Mulle has been named to the new position of director, market development planning, parenteral division, Mead Johnson & Co. He was formerly eastern regional sales manager for that division.

Also at Mead Johnson, Thomas C. Fleming, M.D., has been promoted to the new position of director, product development, research division. He is succeeded as clinical research director by James M. Tuholski, M.D.

Succeeding Dr. Tuholski as associate director, clinical research, is George W. Brown, M.D., formerly assistant clinical research director.

(Continued on page 139)

A *NEW* WEAPON IN THE WAR AGAINST STAPH!



AMERICAN

MATTRESS *and* BEDDING DISINFECTOR *with special* LOADING CAR

A special-purpose Ethylene Oxide unit combining minimum investment and low processing cost with simple, effective operation

AMSCO

AMERICAN STERILIZER

ERIE • PENNSYLVANIA

Write today for bulletin SC-306

(Continued from page 137)

Arthur Bander has been appointed Mead Johnson's eastern district sales manager, parenteral division. He was previously a sales representative for that division.

American Hospital Supply Names International Head

Mr. Hands

H. Williams Hands has been appointed director of international operations, a newly created position at American Hospital Supply Corp. Mr. Hands formerly held the position of general sales manager, International Petroleum Co., Ltd., Lima, Peru.

Another appointment is that of William F. Porter, II, named sales training manager, American Hospital Supply Division. He was previously Chicago regional sales manager. That post has been filled by George H. Olsen, formerly sales representative in the Atlanta and Chicago regions.

Colson Corp. Promotes Two in Sales Positions

D. F. Adams has been appointed vice-president, sales, Colson Corp. and G. Victor Schlitzer has been named Colson's New York district sales manager.

Mr. Adams

Mr. Schlitzer

Mr. Adams has been general sales manager since 1957, and before that, he was sales manager.

Mr. Schlitzer was previously assistant sales manager, eastern region, Ohio Chemical & Surgical Equipment Co.

In American Pavilion's atomic energy exhibit at Brussels International Exhibition, guide demonstrates radio-pharmaceuticals and related equipment produced by Abbott Laboratories. The Abbott products, placed in a setting of up-to-the-minute equipment for operating rooms and laboratories, illustrated the application of atomic energy in combatting disease and prolonging life.

C. Preston Snow Dies

C. Preston Snow, 53, former owner of Hyland Laboratories, died September 27. He purchased Hyland, which he sold in 1955, after resigning as vice-president and general manager of Cutter Laboratories.

Mr. Snow was a past officer and director, American Pharmaceutical Manufacturers Association, American Drug Manufacturers Association, and Manufacturers Surgical Trade Association.

News Briefs

Michael P. Murray, Jr. — will handle Conco Surgical Products, Inc., sales in Pennsylvania, Maryland, Delaware, Virginia, District of Columbia, and southern New Jersey.

* * *

American Instrument Co.—has opened six new sales offices. New office managers and locations are: **Jack Kertzman,** Murray Hill, N.J.; **James J. O'Connor,** Long Island, N.Y.; **W. Donald Finn,** Cleveland, O.; **James A. Fitzsimmons,** Detroit; **Charles R. Jent,** Denver; **Herman C. Zwart,** San Francisco.

* * *

Francis Boyer—chairman of the board, Smith, Kline & French Laboratories, has been appointed to a 2-year term on the National Advisory Arthritis and Metabolic Diseases Council. The council advises the National Institute of Arthritis and Metabolic Diseases, one of the National Institutes of Health, on research awards to nonfederal institutions and scientists.

* * *

T. Newton Silzer—personnel director of the Johnson & Johnson Chicago plant since it opened 25 years ago, has retired. He had been with the company 36 years.

* * *

William Frey—has been appointed district manager, Detroit office, Hospital Division, Wilmot Castle Co.

* * *

William G. Knapp—has been appointed division manager, Abbott Laboratories International Co. He succeeds **B. A. Quinn** who has been named manager of the Abbott affiliate in Spain. Mr. Knapp's successor as manager, South Africa Division, Abbott Universal Ltd., is **Cornelius B. Evers.**

Markets under Mr. Knapp's supervision include those in Bolivia, Brazil, British Guiana, British Honduras, British West Indies, Colombia, Chile, Ecuador, French West Indies, Haiti, Netherlands, Antilles, Puerto Rico, Surinam, Uruguay, and the Virgin Islands.

The Book Corner

Report on Doctors' Offices

Physicians' Private Offices at Hospitals. Study and report of a research project conducted by the Hospital Council of Philadelphia, under the direction of C. Rufus Rorem, Ph.D., Philadelphia: Hospital Council of Philadelphia. 1958. 104 pp. $2.00.

Physician, patient, and hospital benefit from the location of physicians' private offices in hospitals.

This is the over-all conclusion of the report on findings made in the study supported by the U.S. Public Health Service research grant W-62.

Motivation for development of doctors' offices at hospitals has been professional, economic, and administrative, the report further points out. It is predicted that physicians' private offices will be established at more nonprofit community hospitals in the future.

In the study, information was obtained from 28 states and the District of Columbia.

It is emphasized that the report is concerned with physicians' offices at community hospitals, and does not deal with (a) professional service by the owners of proprietary institutions; (b) the full-time staff arrangements at teaching hospitals and other community institutions, and (c) the hospitals owned and conducted by labor unions or large group-payment organizations.

Among subjects discussed in various chapters are: types of private offices, capital financing, legal aspects, selection of tenants, rental rates and policies, and general and special lease provisions.

There are 23 illustrations showing office buildings in various parts of the country. An appendix lists 101 nonprofit short-term hospitals which provide offices for rental to attending staff, and specifies the type of facilities.

EDITOR'S NOTE: Dr. Rorem reported on this study during a roundtable discussion at the annual convention of the American Hospital Association in Chicago in August. Other participants in the discussion were three administrators who described arrangements for provision of physicians' offices at their hospitals. Abstracts of their talks follow.

Reports by Mr. Perdew and Mr. Groner also appear in appendices to the research project report.

Hartford, Conn.:

The doctors' office building adjacent to the Hartford Hospital was built by an insurance company, on property which it owned. The building is operated by the company. However, it is joined on four levels to the hospital.

Operation of the building is separate from that of the hospital, except that the office building buys its steam from the hospital.

The physician tenants planned their own office areas, with the result that they resorted to false economy. For instance, they decided against central air-conditioning. Since then, so many have put in window units that the circuit became overloaded, and the building had to be rewired.

This building has been a great convenience for both the doctors and the hospital. Doctors are near when an emergency arises. Probably this nearness has been a lifesaving factor for many patients. The load in our emergency room has increased well over 10 times.

Unquestionably, the doctors have benefited financially, because they have been able to take more patients.

There are now 115 doctors in space intended to accommodate 90. Many others want to get in. Expansion is being planned. We do not know yet whether the insurance company will make the expansion or whether the hospital may buy the building and expand it.—*T. Stewart Hamilton, M.D.*, executive director, Hartford (Conn.) Hospital.

Kalamazoo, Mich.

The Bronson Medical Center was organized in November, 1948, as a separate corporation which is a nonprofit, wholly-owned subsidiary of the Bronson Methodist Hospital.

Hospital control is assured by having the five directors of the building corporation elected by the hospital's board of trustees. The administrator serves as secretary of the corporation, and the building manager serves as a part-time comptroller of the hospital.

This corporate structure, along with the provision in the articles of association that all net earnings must be paid to the hospital, made it possible for the building corporation to obtain exemption from federal income tax and state sales tax. However, the portion of the building rented to doctors pays a city real-estate tax of approximately $4,000 a year.

Utilities, housekeeping, and maintenance facilities are purchased from the hospital. This arrangement enables us to prove to the public that hospital funds are not being used to subsidize doctors' offices.

BUILDINGS ADJACENT

The hospital and the medical center building are joined by a common wall. From the outside they look like one structure. The hospital uses the building's basement for storage and for the pharmacy, and the first floor for its main lobby, administrative offices, outpatient pharmacy, chapel, snack bar, telephone booths, public rest rooms, and information desk.

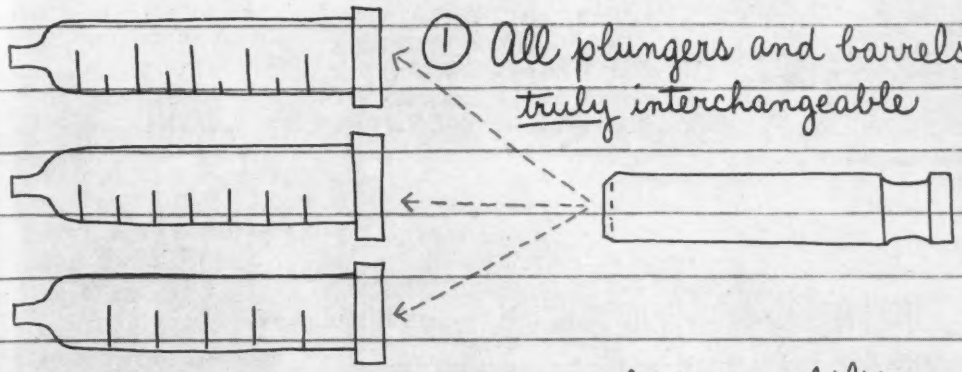
On the two upper floors are 20 suites of offices, occupied by 31 doctors. Average floor space per doctor is approximately 500 square feet. Most doctors wish they had taken 200 feet more. The building is designed so that two additional office floors may be added.

The mortgage loan covered approximately two-thirds of the cost of construction. The other third came from the hospital's building fund. Use of this fund was justified because part of the medical-center building is used for hospital purposes and would have had to be built anyway.

Basic qualification for a tenant is membership on the hospital's medical staff, but such membership does not imply any right to space. Restrictions on use of space in-

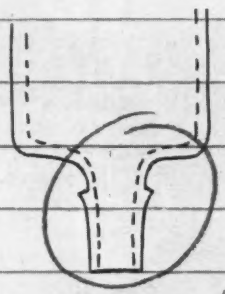
(Continued on page 142)

Syringes + Needles – FEATURES TO LOOK FOR



① All plungers and barrels truly interchangeable

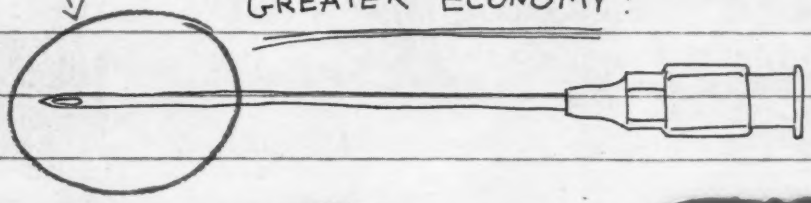
② CLEAR GLASS BARRELS – better visibility more accurate dosage – far outlast ground barrels.

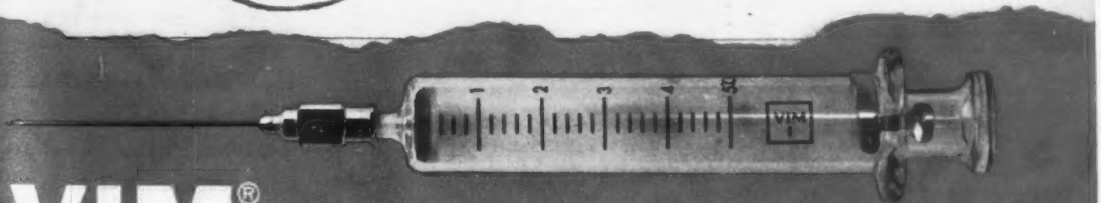


③ NO-LEAK GLASS TIPS available – best type for I.V. use.

④ NEW LAMINEX ALLOY STEEL – stays sharp for double usual no. of injections lasts twice as long as ordinary needle.

GREATER ECONOMY!





VIM®

CLEAR BARREL INTERCHANGEABLE SYRINGES and LAMINEX* NEEDLES—THE ONLY BRAND THAT GIVES YOU ALL 4 KEY PERFORMANCE AND ECONOMY FEATURES!

CYANAMID

AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
DANBURY, CONNECTICUT

*Reg. U. S. Pat. Off.—S. & R. J. Everett Co., Ltd.

PRODUCERS OF DAVIS & GECK BRANDS SUTURES AND VIM BRAND HYPODERMIC SYRINGES AND NEEDLES

DISTRIBUTED IN CANADA BY CYANAMID OF CANADA LIMITED, MONTREAL 16, P. Q.

(Continued from page 140)

clude prohibition of x-ray equipment and operation of a laboratory service for other physicians, because hospital services are fully capable of caring for all such work.

The chief advantage of this building to the public is that the patient finds all his health needs under one roof. A benefit to doctors is the availability of equipment, skilled personnel, and colleagues for consultation. Furthermore, a doctor who has been doing outpatient surgery in his office can transfer it to the hospital outpatient department.

The hospital benefits because the doctors in the office building tend to concentrate their work in the hospital and become more interested in maintaining good hospital standards. Also, outpatients referred from the doctors' offices provide a greater volume for the diagnostic and therapeutic services, enabling lower unit costs for these departments.—*The Rev. W. C. Perdew*, administrator, Bronson Methodist Hospital, Kalamazoo, Mich.

Memphis, Tenn.:

The basic consideration for a hospital deciding to operate a medical office building should be the improvement of patient care. Hospitals which have not acted according to this principle have experienced difficulty in the operation of physicians' offices.

The first doctors' office building at Baptist Memorial Hospital was opened in 1928. The amount of net rentable space has increased from 18,000 square feet in 1928 to 90,000 square feet today.

The 140 doctors now in the three buildings have an average of 650 square feet each.

We do not attempt to make a profit on office space, but rather to have it self-liquidating over a long period of years. The buildings are operated by the administration of the hospital, in order to keep the cost of operation at a minimum and to make sure that policies coincide with the philosophy of the hospital.

There are no leases for tenants, and rents are due at the end of each month. The lower rents make it possible for a man finishing a residency to rent an office at a minimum cost. Increased staff loyalty results.

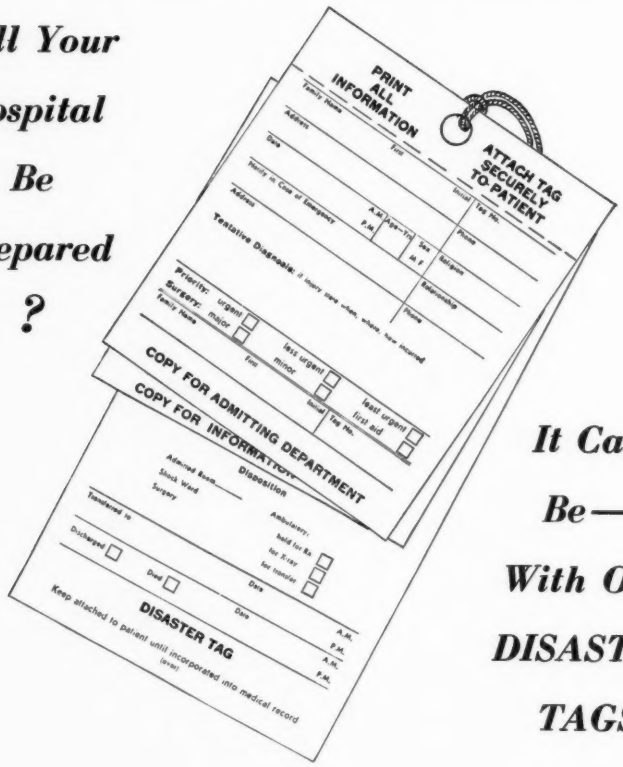
The hospital's educational program is greatly strengthened because members of the faculty are on the campus.

There is an elevation in the level of medical and hospital services rendered the patient. In addition, the extra income helps keep charges to the patient at a minimum, while strengthening the financial stability of the hospital.—*Frank S. Groner*, administrator, Baptist Memorial Hospital, Memphis, Tenn.

Publishers of HOSPITAL and MEDICAL RECORDS since 1907

When* DISASTER *Strikes—

Will Your Hospital Be Prepared ?



It Can Be— With Our DISASTER TAGS

For descriptive circular, write to Dept. 1586

Physicians' Record Company

161 W. Harrison Street • Chicago 5, Illinois

Every issue of HOSPITAL TOPICS has helpful information for all personnel. Wouldn't you like to have a personal subscription?

One year—$4.50

Two years—$7.00

Three years—$9.00

HOSPITAL TOPICS, 30 W. Washington St., Chicago 2, Ill.

PERSONALLY SPEAKING

(Continued from page 64)

director, Missouri Division of Mental Diseases.

Dr. Marcovitch was formerly assistant superintendent, Peoria (Ill.) State Hospital.

S. F. Masson—has been appointed director, Rockford (Ill.) Memorial Hospital. He was previously assistant director, Touro Infirmary, New Orleans. Mr. Masson succeeds **John L. Brown,** who resigned to accept an administrative position in Syracuse, N.Y.

Mrs. E. P. Mitchell—has retired as business manager, Smithville (Kans.) Community Hospital. She has worked for the hospital since it opened in 1938.

Frank F. Morin—has been appointed administrative assistant, Peninsula Hospital, Burlingame, Calif. He was formerly administrative resident at the institution. Mr. Morin received his M.S. degree in hospital administration from the University of California.

Mother M. Michael—has been appointed director, Hospitals of the Sisters of Mercy, Pniladelphia.

Edward T. Newell—resigned as a member of the board of trustees, Tri-County Osteopathic Hospital, Kittery, Me., to become the hospital's administrator.

Michael H. O'Conner — has been appointed administrator of a hospital in Marianna, Ark.

Preston L. Powell — has been named administrator, North Big Horn Hospital, Lovell, Wyo., succeeding **John Pence.**

Robert T. Raker—has become administrator, Tyrone (Pa.) Hospital, succeeding **Stella Austin.** Mr. Raker was previously with Fulton County Medical Center, McConnellsburg, Pa.

Carol Randall, R.N.—has been named director of nursing, St. Luke's Hospital, Cleveland, O. Formerly, she served as director of nursing at Fairview Park Hospital, Cleveland.

Miss Randall is president of the Ohio League for Nursing.

Daniel E. Ray—treasurer, Danvers State Hospital, has accepted an appointment as management analyst, Massachusetts Department of Mental Health.

Harley Rice—former business manager, Porter Sanitarium and Hospital, Denver, is now associate director of health and hospital affairs at the international headquarters for the Seventh Day Adventist Church, Washington, D.C. Replacing Mr. Rice is **O. P. Moline,** who was formerly on the staff of the Hinsdale (Ill.) Sanitarium and Hospital.

Mary Carolyn Rose—former chief dietitian, University of Tennessee Student Clinic and Hospital, Knoxville, has been named director of food services, University Center, Knoxville. She is succeeded at the hospital by **Mrs. Gertrude O'Hara.**

Samuel Samuels—has been appointed administrator, Memorial Hospital of Uinta County, Evanston, Wyo., replacing **Mrs. Warren Olson, R.N. Mrs. Elma K. Cornelison, R.N.,** has been appointed nursing service director at the hospital.

John Setsma, Jr.—has been named personnel director, Good Samaritan Hospital, West Palm Beach, Fla.

Sister Anne Denis, R.N.—has been appointed nursing director, De Paul Hospital, Cheyenne, Wyo. She was previously at St. Joseph's Hospital, Denver.

Sister Anne William—is the new administrator, St. Vincent's Hospital, Bridgeport, Conn. A graduate of the St. Louis University School of Hospital Administration, she succeeded **Sister Margaret,** who has become Sister Treasurer, St. Joseph's Central House, Emmitsburg, Md.

Sister Bernard Maria—has been appointed director of nursing, Our Lady of Peace Hospital, Louisville, Ky. She previously held supervisory and teaching positions at St. Joseph Infirmary in Louisville.

Sister Kathleen Mary—previously director of nursing, Our Lady of Peace Hospital, Louisville, Ky., has been appointed dean, Georgetown University School of Nursing, Washington, D.C. She succeeds **Sister Angela Maria,** who has been appointed director of nurses, St. Joseph Infirmary, Louisville, Ky.

Sister M. Adele—formerly administrator, Seneca (Kans.) Hospital, has been transferred to St. John's Hospital, Salina, Kans.

Sister M. Ferdinand — has been named administrator, Villa Madonna Hospital, Enid, Okla., replacing **Sister Zenona,** who has been transferred to Marion, Kans. Sister Ferdinand was formerly administrator, St. Luke Hospital, Marion, Kans.

Sister Marie—has been appointed administrator, Fitzgerald-Mercy Hospital, Philadelphia.

(Continued on page 146)

$6.40
NEW LOW PRICES!
ZYLON Molded Utensils are now priced well below comparable metallic items . . . yet cannot dent, chip, rust or corrode! Fully autoclavable, the naturally warm, smooth white or aqua plastic eliminates pre-warming and is quieter, for increased patient comfort. See your Distributor for the full Zylon line now at lowest hospital prices ever:
Bed Pan
Emesis Basins
Wash Basins
Medicine Glasses
Forceps Jars
Tumblers
Sponge Bowls,
Soap Dish, etc.
ZYLON PRODUCTS CO., INC.
40 Church St., Pawtucket, R. I., U. S. A.
ZYLON®
MOLDED HOSPITAL UTENSILS

you expect

ATARAX®

(brand of hydroxyzine)

to calm your patients

BUT IN MANY DISORDERS YOU GET ADDED THERAPEUTIC BENEFITS

for example...

IN CARDIAC CONDITIONS

ATARAX *is anti-arrhythmic.* In addition to producing tranquilization, ATARAX "restored and then maintained normal sinus rhythm" in 30 patients with cardiac arrhythmias. All had been refractory to standard measures.[1]

IN ALLERGIC REACTIONS

ATARAX *is antihistaminic, antiserotonin.* Tranquilizers usually have an equivocal effect on allergic disease; ATARAX appears to be the exception.[2] Feinberg reports "striking results" in 15 out of 17 patients with chronic urticaria that cannot be attributed to calming action alone.[2] To date, over 649 cases of allergic dermatoses have responded favorably to ATARAX.[3,4]

IN GASTRIC DISTURBANCES

ATARAX *is antisecretory,[5] antispasmodic,[6] and antitensive.* Both emotional and physical aspects of gastric disorders are controlled by ATARAX. Treatment of peptic ulcer, epigastralgia, aerophagia with painful eructations, and colic of spastic origin, has yielded promising results.[5,6]

ATARAX®

FOR MORE THAN ATARACTIC ACTION

DOSAGE: *Adults,* one 25 mg. tablet or 1 tbsp. syrup q.i.d. *Children,* 1-2 10 mg. tablets or 1-2 tsp. syrup t.i.d.
SUPPLIED: Prescription only. *Tablets,* 10 mg., 25 mg., and 100 mg., bottles of 100. *Syrup,* pint bottles. *Parenteral Solution,* 10 cc. multiple-dose vials.

1. Burrell, Z. L., et al.: Am. J. Cardiol. *1*:624 (May) 1958. 2. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 3. Eisenberg, B. D.: Clin. Med. *5*:897 (July) 1958. 4. Robinson, H. M., Jr., et al.: South. M. J. *50*:1285 (Oct.) 1957. 5. Strub, I. H.: Personal communication. 6. Schuller, B.: Gaz. des Hôpitaux No. *10*:391 (Apr. 10) 1957.

Roerig Rx NEW YORK 17, N. Y. | DIVISION, CHAS. PFIZER & CO., INC. SCIENCE FOR THE WORLD'S WELL-BEING

PERSONALLY SPEAKING

(Continued from page 143)

Sister Marie Immaculate — has been named administrator, Misericordia Hospital, Philadelphia.

Sister Mary Alfreda — has been appointed administrator, Sacred Heart Hospital, Lamar, Colo., replacing **Sister Mary Pauline.**

Sister Mary Bertrand, R.N.—has been transferred to St. John's Hospital, St. Louis. She was previously administrator, St. John's Hospital, Springfield, Mo. **Sister Mary Chrysostom** succeeds her at the Springfield hospital.

Sister Mary Gertrude — has been appointed associate director, St. Francis Hospital School of Nursing, Hartford, Conn. She was previously director of nursing service, and assistant to the director, St. Mary's Hospital School of Nursing, Waterbury, Conn.

Sister Mary Martha Hund — has been named director of nursing, St. Joseph's Hospital, Omaha, Nebr. She succeeds **Sister Mary Louis Wenzl,** who has been appointed administrator, Good Samaritan Hospital, Kearney, Nebr.

Sister Mary Martha was formerly director of nursing, St. Elizabeth Hospital, Lincoln, Nebr.

Sister Mary Robert—formerly of Seneca (Kans.) Hospital, has been named administrator, St. John's Hospital, Salina, Kans. She replaces **Sister M. Ferdinand,** who has been transferred to St. Joseph's Hospital, El Paso, Tex.

Martha Skarabotta, R.N.—has been appointed director of nursing, Lutheran Hospital, Cleveland, O. Previously she taught surgical nursing and was student nurse supervisor at Cuyahoga County Hospital, Cleveland.

Marjorie F. Snyder, R.N.—has been appointed director of nursing, Winchester Hospital, Lawrence, Mass. She was previously director of nursing, Providence Memorial Hospital, El Paso, Tex., and had also served as assistant director of nursing, Oakwood Hospital, Dearborn, Mich.

G. Verne McGilvreay, R.N., has been selected as Winchester's assistant director of nursing. She was previously fourth floor supervisor.

Lee M. Thomas—has been appointed administrator, Walton County Hospital, DeFuniac Springs, Fla. He recently completed the hospital administration course at Georgia State College of Business Administration, Atlanta.

Bernard Weinstein—has been named administrative assistant, Albert Einstein Medical Center, Philadelphia.

Paul Whitall—has been named comptroller, Episcopal Hospital, Philadelphia.

Arthur Wilson—has been named administrator, Saline Memorial Hospital, Benton, Ark.

J. C. Wong, Ph.D.—has been appointed administrator, Doctors' Hospital, Toronto, Ont., Canada.

N. J. Zaccaria—has been appointed credit officer, East Orange (N.J.) General Hospital. He was former-

How effective is Blanket Disinfection?

There's little doubt that the hospital blanket which is in such close contact with the patient offers a fertile field for spreading infection. Confirmation by bacteriologic tests usually reveals a surprisingly high count under ordinary blanket use situations.

Efforts to eliminate this reservoir for spreading staph (and other potentially dangerous organisms such as tubercle bacilli) have stimulated controlled studies in many hospitals... and the consequent adoption of routine disinfection of blankets between patients. For example—

In New Hampshire, Adams[1,2] hospital added Amphyl® disinfectant to routine laundering of blankets as patients changed, or earlier if soiling occurred, with the result that "it renders them routinely sterile" and also "this disinfectant neither shrinks nor discolors blankets."

In Washington, Ravenholt and others[3,4] tested Amphyl for disinfecting hospital blankets heavily contaminated with staph. Their findings indicate that "the addition of a synthetic phenolic disinfectant Amphyl achieves virtual elimination of staphylococci on the blankets. Routine use of the tested disinfectant for washing blankets, pillows, and all laundry materials, as well as for surface disinfection, in a Seattle tuberculosis sanatorium for seven years has demonstrated that the disinfectant does not injure fabrics or other materials nor cause sensitivity reactions in personnel or patients. On the basis of these findings, the synthetic phenol used in these studies appears to be a suitable compound for use in blanket disinfection."

Practical problems of laundry handling as well as the bactericidal and tuberculocidal effects of Amphyl have been considered in these reports. We hope you will find each article helpful in making Amphyl blanket disinfection routine in your own laundry. Also, Lehn & Fink's technical staff is always ready to assist you in strengthening control of cross infection in any area of your hospital. Just write us at 445 Park Avenue, New York 22, N. Y.

We will be glad to send these reprints.

Professional Division
Lehn & Fink Products Corporation

1. Adams, Ralph: Med. Times, 86:1119-1127 (Sept.) 1958.
2. Adams, Ralph: Resident Physician, 4:112-132 (Sept.) 1958.
3. Ravenholt, Otto H., and others: Hospitals, 32:75-80 (June 16) 1958.
4. Ravenholt, Otto H.,and others: Med. Bull. U. of Minn. 29:421-429 (May 1) 1958.

© Lehn & Fink Products Corporation 1958

ly accounts manager, St. Francis Hospital, Jersey City, N.J.

Named purchasing agent at East Orange Hospital was **Robert L. Blanks**. He was formerly purchasing agent at Christ Hospital in Jersey City.

Louis L. Zmek—has been appointed assistant administrator, Benedictine Heights Hospital, Guthrie, Okla. He was previously administrator, Hominy City (Okla.) Hospital.

VA Appointments

Ralph F. Metheny, M.D. — is the new manager of both the Jamaica Plain (Mass.) VA Hospital and the West Roxbury VA Hospital, Boston. **John V. Sheehan** is the West Roxbury assistant manager.

John J. Gallagher has been transferred from the Jamaica Plain hospital to the VA Center, Bath, N.Y., as assistant manager.

Dr. Metheny was formerly manager, Albany (N.Y.) VA Hospital. He is succeeded there by **Richard B. Bean, M.D.**, who was formerly manager of the Jamaica Plain hospital.

John F. Norwood—has been named assistant chief, registrar division, VA Research Hospital, Chicago.

James W. Raleigh, M.D.—has succeeded **Edward Dunner, M.D.**, as VA co-ordinator, research on chest diseases. Dr. Raleigh was formerly chief, pulmonary disease service, VA Hospital, Sunmount, N.Y.

Edward F. Zimmerman, M.D.—has been appointed manager, VA West Side Hospital, Chicago. He succeeds **Lee H. Schlesinger, M.D.**, who was appointed VA area medical director, Columbus, O. Dr. Zimmerman was formerly director, professional services, Coral Gables (Fla.) VA Hospital.

VA Nursing Appointments

Margaret Ambury, R.N.—has been transferred as chief, nursing service, to VA Hospital, Altoona, Pa. She formerly held a similar position at the Manchester (N.Y.) VA Hospital.

Lillie Brown, R.N.—is chief, nursing service, West Side VA Hospital, Chicago. Prior to transfer she was assistant chief, nursing service, Hines (Ill.) VA Hospital.

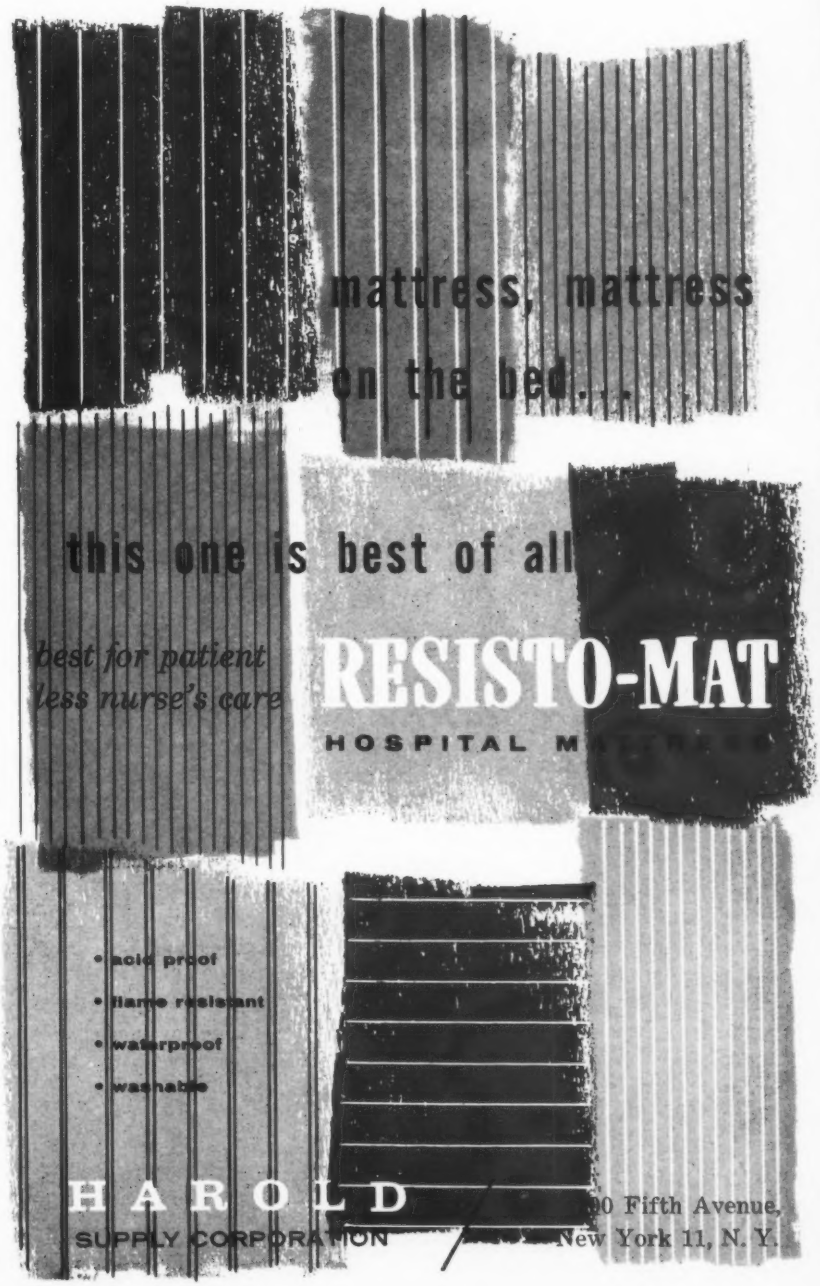
Velva Chapman, R.N. — has been transferred as chief, nursing service, to the VA hospital, Pittsburgh. Previously, she held a similar position at the Richmond (Va.) VA Hospital.

Genevieve Coleman, R.N.—is chief, nursing service, VA Hospital, Rutland Heights, Mass. Prior to transfer she was assistant chief, nursing service, Boston VA Hospital.

Ruth Frothingham, R.N. — has been transferred as chief, nursing service, to the VA Hospital, Brooklyn, N.Y. Prior to transfer she was assistant chief, nursing service, Denver VA Hospital.

Edna Gordon, R.N.—has been appointed assistant chief, nursing education, VA Hospital, Pittsburgh.

(Continued on next page)



Now, for the first time, a lamp mounted on a bedside cabinet *(by Hill-Rom)*

puts the light right where you need it

Here, for the first time, is a lamp placed where a hospital lamp should be placed—on the bedside cabinet within easy reach of the patient, yet out of the way of the nurse. This new Hill-Rom lamp is attached to the back side of the cabinet. It rolls on a track, so may be used on either side of the cabinet. It may also be moved entirely out of way when full access to the top of the cabinet is desired.

A parabola shade inside the outer shade permits spotting the light when intensive light is needed for examination. Inverting the shade gives indirect light. The shade is ventilated—will never become hot. A convenience outlet permits plugging in any electric appliance used at the bedside.

This lamp is completely approved by Underwriters' Laboratories, Inc. as safe for hospital use. Complete information on request.

HILL-ROM COMPANY, INC. • Batesville, Indiana

PERSONALLY SPEAKING continued

Previously she was assistant professor, Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland, O.

Emily Gross, R.N. — has been transferred as chief, nursing service, VA Hospital, Syracuse, N.Y. Prior to transfer she was assistant chief, nursing service, VA Hospital, Albany, N.Y.

Muriel Harley, R.N.—is assistant chief, nursing service, VA Hospital, Boston, at which she was formerly a supervisor.

Evelyn Houff, R.N.—has been appointed chief, nursing unit, Hartford, Conn., VA regional office clinic. Prior to transfer she was a staff nurse at the Baltimore VA clinic.

Lucie Hutchison, R.N.—is assistant chief, nursing education, VA Hospital, Marion, Ind. She was previously assistant chief, nursing service, Chillicothe (O.) VA Hospital.

Elizabeth Jung, R.N.—has been appointed chief, VA San Francisco area nursing service. Prior to appointment she was assigned to the office of the area medical director, St. Paul, Minn.

Martha Kern, R.N. — has been named assistant chief, nursing education, Gulfport division, VA Hospital, Biloxi, Miss. She previously held a similar position at Jefferson Barracks, Mo.

New Officers

Robert D. Howe, administrator, Billings Deaconess Hospital, was elected president of the Montana Hospital Association at its recent annual meeting in Havre. Also elected were: **Sister Mary Thomas More,** administrator, St. Joseph's Hospital, Lewistown, president-elect; **C. T. Holland,** administrator, Broadwater Hospital, Townsend, vice-president; and **William B. Talbot, M.D.,** administrator, Butte Community Memorial Hospital, secretary-treasurer. **William A. Guy,** Great Falls, remains executive secretary.

* * *

John H. Zenger, administrator, Utah Valley Hospital, Provo, was

(Continued on page 150)

One minute kill for resistant strains of staphylococcus aureus

A concentrated iodophor germicide with quick, non-selective killing power, non-toxic in use dilutions...

Announcing

IOCLIDE®

KILLS SPORES, VIRUSES, BACTERIA

including tubercle bacillus

Concentrated IOCLIDE® is inexpensive, easy-to-store, easy to prepare... simply mix with water

Directions show recommended dilutions for all uses

= 2½ gals.

26 ml. bottle makes up to 2½ gallons of germicide

= 51½ gals.

Pint polyethylene container makes up to 51½ gallons

= 103 gals.

Quart polyethylene container makes up to 103 gallons

FAST

IOCLIDE disinfects in a few minutes

PENETRATING

Detergent action reaches contaminating deposits, tissues, proteins... cleanses metallic, glass, plastic, rubber surfaces

VERSATILE

Ideal for emergency disinfection, and for disinfecting equipment which does not tolerate steam sterilization

NON-IRRITATING, ODOR-FREE

Common disadvantages of corrosiveness, skin irritation, staining and oppressive odors are minimized

COLOR TELLS STRENGTH —at a glance!

Variations in amber color of dilutions always provide a positive visual check of killing power

Write for brochure on IOCLIDE, with complete statistical and microbiological data.

Clay-Adams

141 East 25th St., New York 10, N. Y.

Your dealer has IOCLIDE, now. Call him today.

PERSONALLY SPEAKING

(Continued from page 148)

elected president, Utah Tuberculosis and Health Association, at the group's recent annual meeting in Salt Lake City. Other officers named were: **Mrs. D. C. Dix,** Logan, vice-president; **La Verna Peterson, R.N.,** Ogden, secretary; and **Howard S. Winters,** Salt Lake City, treasurer.

* * *

William Heller, chief pharmacist, University of Arkansas Medical Center, Little Rock, was named president-elect, American Society of Hospital Pharmacists, in the group's recent balloting. He will take office at the annual meeting of the society in Cincinnati, in April, 1959.

Other officers named are: **Vernon Trygstad,** director, pharmacy service, Department of Medicine and Surgery, VA, Washington, D.C., vice-president-elect; **Sister M. Berenice,** director, pharmacy service, St. Mary's group of hospitals, St. Louis University, St. Louis, and present society treasurer, treasurer-elect. **Gloria Francke,** Ann Arbor, Mich., will continue as secretary.

* * *

Lad Grapski, director, University Hospital, Baltimore, became president of the University of Chicago Hospital Administration Alumni Association at its annual meeting held in Chicago in August. He succeeds **Delbert L. Price,** administrator, Children's Memorial Hospital, Chicago.

Other officers elected were: **Joseph F. Friedheim,** director, Jameson Memorial Hospital, New Castle, Pa., vice-president and president-elect; **Catherine M. Maloy,** administrator, Woman's Hospital, Detroit, secretary; **Bertram G. Hanson,** administrator, Memorial Hospital of McHenry County, Woodstock, Ill., treasurer.

Deaths

Arthur H. Brittingham — 54, administrator of the Easton (Pa.) Hospital since 1944, died September 3. He was formerly superintendent, Northeast Hospital, Philadelphia.

Mr. Brittingham was president, Eastern Hospital Association, 1949-1950, and in 1951 he served as second vice-president, Hospital Association of Pennsylvania.

Ralph Hill, M.D.—82, retired superintendent, Wernersville (N.Y.) State Hospital, died August 22. He headed the hospital for 27 years until his retirement in 1954. Dr. Hill was a past president of the Berks County Medical Society.

Chevalier Jackson, M.D.—92, internationally known laryngologist, died August 16. Noted for his perfection of bronchoscope technic, he founded the Jackson Bronchoscopic Clinic at Temple University, Philadelphia, which his son, Chevalier L. Jackson, M.D., now heads.

Dr. Jackson had been honored by several foreign governments and was the recipient of the Philadelphia Award and the American Medical Association's Distinguished Service Medal.

Ruth MacMaster — administrator, Memorial Hospital, Wayne, W. Va., died June 28. She had served with the U.S. Army Reserve Medical Corps at Fort Knox, Ky., during World War I.

Jessie Stewart, R.N.—44, assistant director, Massachusetts General Hospital School of Nursing, Boston, died August 28. Previously she had been a supervisor, Massachusetts Eye and Ear Infirmary.

Armed Forces Medical Journal Editor Named

Col. Robert J. Benford, USAF (MC), has been named director, Armed Forces Medical Publication Agency, and editor, *U.S. Armed Forces Medical Journal.* He succeeds Capt. Bennett F. Avery, USN (MC), who has been appointed national coordinator, Medical Education for National Defense program.

Col. Benford previously was editor, *Journal of Aviation Medicine.* He also wrote *Doctors in the Sky,* a history of aviation medicine.

Diamond Edges keep scissors sharp for years!

New OCHSNER Diamond edge scissors have tungsten-carbide edges, (hardest metal known to man) laminated to tough Swedish surgical steel.

Razor edge sharpness is maintained up to 100 times longer than conventional surgical-type scissors.

Easy to recognize, ring handles are gold plated for quick and easy identification.

Available in the following sizes:

METZENBAUM	Light dissecting scissors	$5\frac{3}{4}$″ curved	$15.30
	Light dissecting scissors	$5\frac{3}{4}$″ straight	$15.30
	Dissecting scissors	7″ curved	$15.30
	General dissecting scissors	9″ curved	$26.25
MAYO	Dissecting scissors	$5\frac{1}{2}$″ straight	$14.25
	Dissecting scissors	$5\frac{1}{2}$″ curved	$15.30
	Dissecting scissors	$6\frac{3}{4}$″ straight	$14.50
	Dissecting scissors	$6\frac{3}{4}$″ curved	$15.50
GENERAL	Dissecting scissors-Mayo points	9″ curved	$25.75
	Dissecting scissors-Mayo points	9″ straight	$24.75

Snowden-Pencer Corporation ◆ P. O. Box 186, Los Gatos, Calif.

NEW AS TOMORROW'S SURGERY

The AMERICAN *ten eighty five* Major Surgical Operating Table

- ✶ **Compact, permanently mounted base with electro-hydraulic or hydraulic power lift**
- ✶ **Divided and removable foot section**
- ✶ **Head, back and seat sections X-ray penetrable**
- ✶ **Sliding Transurethral Tray**
- ✶ **"Winged" ether screen**

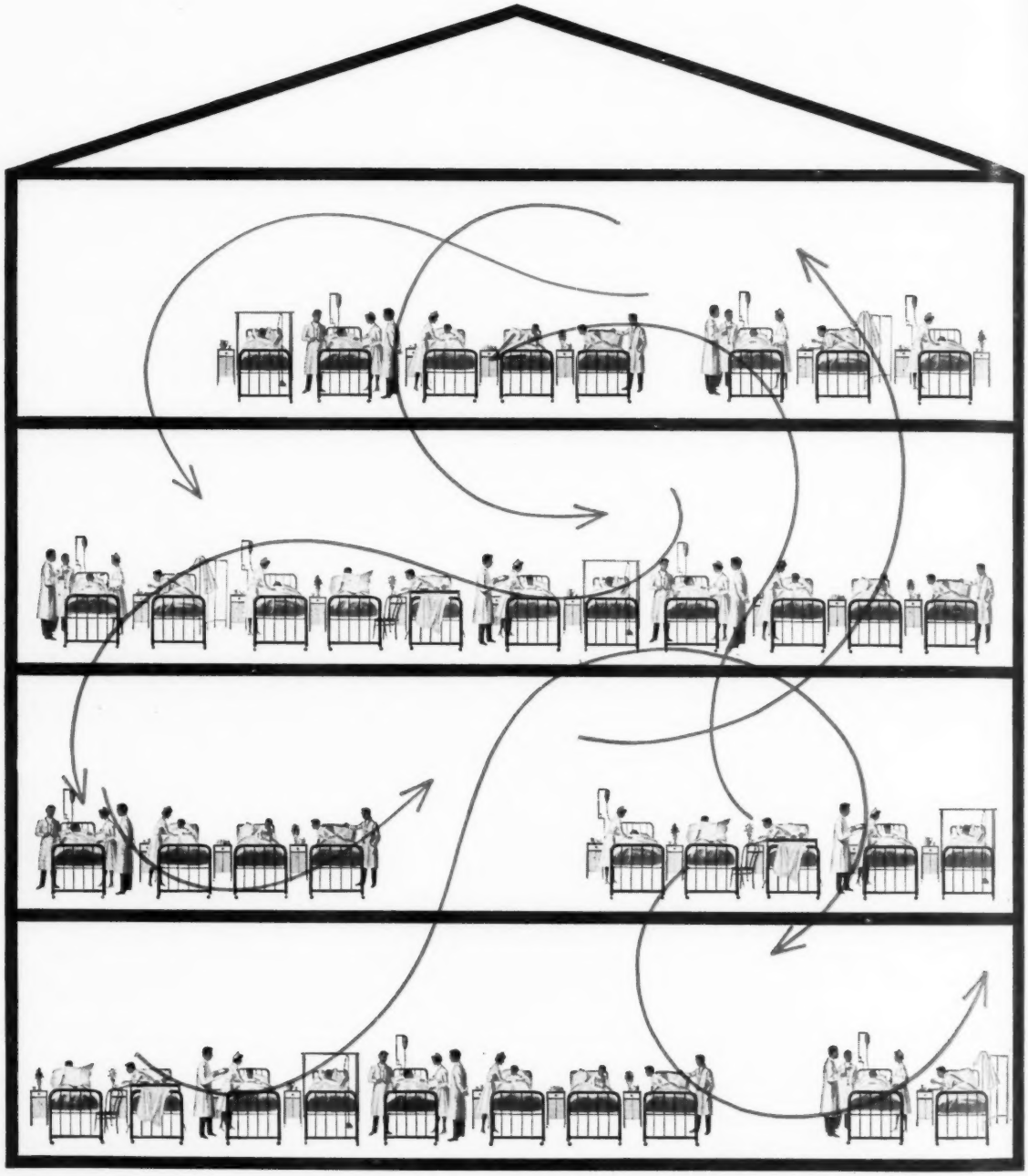
. . . these and many more exclusive features distinguish the 1085 as the major table *designed for modern surgery*.

The unparalleled versatility and precision of this new table are an incomparable aid to the surgical team . . . as helpful to the patient as "a third hand for the surgeon."

Write for your copy of illustrated brochure TC-294.

The 1085 is an addition to the Amsco line of Major Surgical Tables. The 1080 and 1080E will continue to be available.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA



STOP "HOSPITAL STAPH" WITH ALBAMYCIN*

Antibiotic-resistant strains of Staphylococcus are meeting their match in Albamycin. Because Albamycin shows no cross resistance with any commonly used antibiotic, it is dramatically effective against unyielding staphylococcal pneumonia or superinfections of pneumococcal pneumonia.

Whether resistant staph is known or suspected, *Albamycin is indicated.*

ADMINISTRATION AND DOSAGE: The dosage for adults is 500 mg. Albamycin administered intramuscularly or intravenously every 12 hours. As soon as the patient's condition permits, parenteral Albamycin should be replaced with oral Albamycin therapy.

SUPPLIED: Available as 250 mg. capsules; syrup containing 125 mg. Albamycin per 5 cc.; and in the 500 mg. Mix-O-Vial.†

The Upjohn Company, Kalamazoo, Michigan

Upjohn

*TRADEMARK, REG. U. S. PAT. OFF.—
THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM
†TRADEMARK, REG. U. S. PAT. OFF.

BUYER'S GUIDE Information Service

BUYER'S GUIDE

700. Electrocardioscope
701. Econocape
702. Patient lighting
703. Plastibell
704. Blood bag
705. Piped oxygen outlet
706. Truck bumper
707. Volumetric pipetter
708. Flexible straw
709. Coplin jar
710. Surgical tape
711. Interchangeable syringe
712. Surgical stool
713. Enemas
714. Plastic tumbler
715. Alumafoam fence splint
716. Eye model
717. Instrument cabinet
718. Floor mat
719. Aluminum sink
720. Grip exerciser
721. Dia-Pump
722. Memorial book
723. Kleen-Air odor tent
724. Blade dispenser
725. Ice maker
726. No-chip decanter
727. Wall switch
728. Container stand
729. Garbage-refuse disintegrator
730. Thermometer calibrating bath
731. X-ray amplifier
732. Jet-steam cooker
733. Mechanical convection oven
734. Imbedment panel
735. Micro-Filter for Isolette
736. Payroll tax computer
737. Hand labeler
738. Blood donor lounge
739. Linen marker
740. Boltless shelving
741. Oxygen tank
742. Sensi-disc dispenser
743. Protective cream
744. Storage hut
745. Plaster of Paris
746. Fork lift truck
747. Propane diluter
748. Surgical suture
749. Aluminum foil
750. Cylinder cart
751. Light duty caster
752. Vertical file
753. Disposable decanter
754. Measuring pitcher

FILMS, NEW LITERATURE

760. Laboratory glassware
761. Gas sterilization
762. Ultracentrifugation
763. Tapes
764. X-ray microscope
765. Hot water heat
766. Disaster tags
767. Stretcher system

USE THIS CARD

Just circle the number on the postpaid reply card for information you would like.

ACS CONVENTION

C-780. Cross-circulation pump
C-781. Chest respirator
C-782. Cardiac suture
C-783. Hip nail rack
C-784. Elastic foam bandage
C-785. Dry-heat sterilizer

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD
First Class Permit No. 34341, Chicago, Illinois

HOSPITAL Topics
30 West Washington Street
Chicago 2, Ill.

C-1	C-14	C-27	C-40	C-53	C-66	705	718	731	744	762
C-2	C-15	C-28	C-41	C-54	C-67	706	719	732	745	763
C-3	C-16	C-29	C-42	C-55	C-68	707	720	733	746	764
C-4	C-17	C-30	C-43	C-56	C-69	708	721	734	747	765
C-5	C-18	C-31	C-44	C-57	C-70	709	722	735	748	766
C-6	C-19	C-32	C-45	C-58	C-71	710	723	736	749	767
C-7	C-20	C-33	C-46	C-59	C-72	711	724	737	750	C-780
C-8	C-21	C-34	C-47	C-60	C-73	712	725	738	751	C-781
C-9	C-22	C-35	C-48	C-61	700	713	726	739	752	C-782
C-10	C-23	C-36	C-49	C-62	701	714	727	740	753	C-783
C-11	C-24	C-37	C-50	C-63	702	715	728	741	754	C-784
C-12	C-25	C-38	C-51	C-64	703	716	729	742	760	C-785
C-13	C-26	C-39	C-52	C-65	704	717	730	743	761	C-49a

Send more information on items circled. NOVEMBER, 1958

Name ..... Position .....
(Please Print)

Hospital .....

Address .....

City ..... Zone ..... State .....

BUYER'S GUIDE Information Service

ADVERTISER'S INDEX

		Page
C-1	Air-Shields, Inc.	90
C-2	American Cyanamid Co.	41
C-3	American Cyanamid Co.	43
C-4	American Cyanamid Co.	141
C-5	American Sterilizer Co.	138
C-6	American Sterilizer Co.	151
C-7	Ames Co., Inc.	84
C-8	Anchor Brush Co.	34
C-9	Gordon Armstrong Co.	88
C-10	A.S.R.	109
C-11	C. R. Bard, Inc.	93
C-12	Bard-Parker Co., Inc.	3rd cover
C-13	Bauer & Black	127
C-14	Baxter Laboratories, Inc.	46-47
C-15	Becton, Dickinson & Co.	133-136
C-16	The Birtcher Corp.	77
C-17	Bristol Laboratories Inc.	35-36
C-18	Wilmot Castle Co.	17-18
C-19	Chesebrough-Pond's, Inc.	83
C-20	Clay-Adams, Inc.	149
C-21	Crescent Surgical Sales Co.	132
C-22	Cutter Laboratories	100
C-23	Davol Rubber Co.	4
C-24	J. A. Deknatel & Son, Inc.	128
C-25	Dennison Mfg. Co.	131
C-26	Dittmar and Penn Corp.	60
C-27	Duxe Products	39
C-28	Ethicon, Inc.	53-54
C-29	Ethicon, Inc.	98-99
C-30	Falcon Plastics	89

The Advertisers' Index will appear on this card every month. Further information on products listed in advertisements may be obtained by circling the appropriate number on the reply card.

		Page
C-31	Flex-Straw Co.	61
C-32	Gudebrod Bros. Silk Co., Inc.	11
C-33	Thomas W. Halliday	53
C-34	Harold Supply Corp.	147
C-35	Hausted Mfg. Co.	1
C-36	Hill-Rom Co., Inc.	148
C-37	Franklin C. Hollister Co.	62
C-38	HOSPITAL TOPICS	107
C-39	Huntington Laboratories, Inc.	97
C-40	Hyland Laboratories	122
C-41	Johnson & Johnson	75-76
C-42	Mary A. Johnson Associates	112
C-43	Lakeside Laboratories, Inc.	4th cover
C-44	Lehn & Fink Products Corp.	146
C-45	Eli Lilly and Co.	8
C-46	The MacBick Co.	111
C-47	Meinecke & Co., Inc.	130
C-48	Metro Medical Distributors, Inc.	15
C-49	E. Miltenberg, Inc.	123
C-49a	Minnesota Mining & Mfg. Co.	95
C-50	V. Mueller & Co.	80
C-51	Omega Precision Medical Instruments Co., Inc.	10
C-52	Parke, Davis & Co.	96
C-53	The Pelton & Crane Co.	66
C-54	Physicians' Record Co.	142
C-55	The Pioneer Rubber Co.	65
C-56	J. T. Posey Co.	121
C-57	Professional Tape Co., Inc.	59
C-58	Roerig	144-145
C-59	Shampaine Co.	14
C-60	Shampaine Electric Co., Inc.	13
C-61	Shampaine Industries	12
C-62	Shay Medical Agency (Classified)	64
C-63	J. Sklar Mfg. Co.	63
C-64	Smith & Underwood	124
C-65	Snowden-Pencer Corp.	150
C-66	Tailby-Nason Co., Inc.	16
C-67	Travenol Laboratories, Inc.	2nd cover
C-68	The Upjohn Co.	3, 152
C-69	Edward Weck & Co.	57
C-70	Harry Wells	33
C-71	Winthrop Laboratories	9
C-72	Woodlets, Inc.	66
C-73	Zylon Products Co., Inc.	140

C-1	C-14	C-27	C-40	C-53	C-66	705	718	731	744	762
C-2	C-15	C-28	C-41	C-54	C-67	706	719	732	745	763
C-3	C-16	C-29	C-42	C-55	C-68	707	720	733	746	764
C-4	C-17	C-30	C-43	C-56	C-69	708	721	734	747	765
C-5	C-18	C-31	C-44	C-57	C-70	709	722	735	748	766
C-6	C-19	C-32	C-45	C-58	C-71	710	723	736	749	767
C-7	C-20	C-33	C-46	C-59	C-72	711	724	737	750	C-780
C-8	C-21	C-34	C-47	C-60	C-73	712	725	738	751	C-781
C-9	C-22	C-35	C-48	C-61	700	713	726	739	752	C-782
C-10	C-23	C-36	C-49	C-62	701	714	727	740	753	C-783
C-11	C-24	C-37	C-50	C-63	702	715	728	741	754	C-784
C-12	C-25	C-38	C-51	C-64	703	716	729	742	760	C-785
C-13	C-26	C-39	C-52	C-65	704	717	730	743	761	C-49a

Send more information on items circled. NOVEMBER, 1958

Name ..... Position .....
(Please Print)

Hospital .....

Address .....

City ..... Zone ..... State .....

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD
First Class Permit No. 34341, Chicago, Illinois

HOSPITAL *Topics*

30 West Washington Street
Chicago 2, Ill.

WHEN A TIME-TESTED PRODUCT
GETS A NEW, TIME-SAVING PACKAGE...

RESULT... **ease of application** — while it's still in the package, blade can be attached to knife handle

RESULT... **strong, sturdy package** — puncture proof, moisture proof wrap withstands repeated handling and can be autoclaved

RESULT... **complete blade protection** — maximum sharpness of these traditionally superior **carbon** steel blades assured

Ask your dealer

It's Sharp

B-P Sterile Blade Dispenser Rack

BARD-PARKER COMPANY, INC.
DANBURY, CONNECTICUT
A DIVISION OF BECTON, DICKINSON AND COMPANY

B-P • RIB-BACK • IT'S SHARP are trademarks of BARD-PARKER

a MUST for the hospitalized cardiac... dependable, rapid diuresis

No one is more aware than professional hospital personnel that in acute fluid retention (cardiac failure), a diuretic regimen is a **MUST**. And the diuretic used **MUST** be dependable—**MUST** always provide maximum therapeutic benefits, rapidly, with minimal side effects.

For this reason, the standard procedure in the majority of hospitals is initial injection of MERCUHYDRIN to obtain the rapid, adequate diuresis that is often lifesaving.

Once acute symptoms have been controlled, NEOHYDRIN, the proved, effective oral diuretic, maintains the edema-free state.

The many years of dependable experience with MERCUHYDRIN and NEOHYDRIN have demonstrated that supplemental potassium is usually not needed, and other special diets are rarely required. Therefore, this diuretic team saves precious time for hospital personnel and patient alike—time that may be utilized by the staff for other hospital tasks; time that shortens hospital stays.

standard for initial control of severe failure
MERCUHYDRIN®
(Brand of Meralluride Injection) sodium

for maintenance of the edema-free state
TABLET
NEOHYDRIN®
(Brand of Chlormerodrin)

NEOHYDRIN®
WITH **VITAMINS**
(Brand of Chlormerodrin with B-complex and ascorbic acid)

LAKESIDE

20395